

Prior Authorization and the Cost of Health Care



It seems to me that nearly every diagnostic test or therapeutic intervention that I order, except for the most common blood tests and standard radiographs, requires prior authorization from the patient's health insurance company. Obtaining prior authorization usually requires extra telephone calls or electronic communications of some sort, and often delays procurement of the information needed to make a definitive diagnosis and institute proper treatment; this can affect care and the doctor-patient relationship. There is, moreover, an administrative cost to this process, both for the insurance company and my office, not to mention the frustrations experienced by my patients and staff, and me. Regrettably, this complicated administrative procedure uses up valuable health care money that could potentially be used differently if the tests and procedures were appropriately ordered and executed without the impediment posed by the prior authorization requirement.

To provide some perspective on this, I recommend that those who are interested read the report by Papanicolas et al (1), the findings of which I will summarize here. The United States, as with Canada, the United Kingdom, the Netherlands, France, Germany, Switzerland, Sweden, Denmark, Japan, and Australia, is considered to be a high-income country; yet, health care spending as a percentage of gross domestic product (GDP) in the United States is substantially greater than it is in any of these other countries. In fact, analysis of data from the Organization for Economic Co-operation and Development and other international sources, for the years 2013 through 2016, indicates that the United States spent 17.8% of its GDP on health care, whereas spending in the other high-income countries mentioned ranged from 9.6% in Australia to 12.4% in Switzerland. Of interest, the United States also ranked last in proportion of the population with health insurance (90% compared with 99% to

100% for the other countries), and first in proportion of private insurance (55.3%). Unfortunately, despite the United States' greater amount of health care expenditure, life expectancy was lowest in the United States at 78.8 years, whereas it ranged from 80.7 to 83.9 years in the other high-income countries. Moreover, in regard to infant mortality and obesity, the United States ranked highest, whereas it ranked second to last in this group of countries in terms of the percentage of the population that smoked. In regard to the number of physicians and nurses in the workforce and the number of hospital beds, no substantial differences were noted. As for the use of magnetic resonance and computed tomography scans, the United States ranked highest among the 11 high-income countries; in regard to the use of services for the treatment of acute myocardial infarction, pneumonia, chronic obstructive pulmonary disease, hip and knee replacement, and coronary artery bypass graft surgery, no substantial differences in per capita use were observed. The United States, however, led the way in terms of the amount of money spent on the administrative costs of care, which entails planning, regulating, and managing health systems and services, and these costs accounted for approximately 8% of the US GDP, whereas in the other countries, it ranged from 1% to 3%. Furthermore, per capita pharmaceutical costs in the United States were \$1443, whereas in the other countries they ranged from \$466 to \$939. Finally, salaries for physicians and nurses were highest in the United States at \$218,173, compared with a \$86,607 to \$154,126 range in the other countries. Based on these findings, Papanicolas et al concluded that, despite similar rates of utilization, the United States spent nearly twice as much as other high-income countries on medical care. It was the higher cost of goods and services, including pharmaceuticals and administrative costs, that appeared to be the major drivers of the difference in overall cost.

So, it appears that the higher amount of spending here in the United States is not related to the provision of more services per capita and that higher costs do not yield a greater degree of health. The greater expenditure does, however, fund higher pay for providers, pharmaceuticals, and an administrative bureaucracy that costs far more than it does in other high-income countries. I can't help but think that a substantial reduction in the administrative cost of health care in the United States, which currently accounts for approximately 8% of our GDP, could reduce the 17.8% of GDP that we currently spend on health care, such that our total expenditure would approach the 9.6% spent in Australia or the 12.4% spent in Switzerland, for health care overall.

Now, when a test or treatment that I reasonably order gets held up because we have to wait for prior authorization, the thought of an administrative bureaucracy eating up our health care dollars frustrates me even more. This problem of administrative costs needs to be considered at the highest levels of our government and remedied. Concern for this is, of course, nothing new, even though the prior authorization menace seems to be more prevalent lately. Perhaps the quickest way to remedy the problem is to convert to a single-payer system, although, in the United States, that concept runs into a wall of resistance. Cutler et al (2), in 2012, discussed the huge potential savings that could be realized if health care transactions were conducted electronically, clinical and administrative

health systems were fully integrated (so the insurance company would know why I am ordering magnetic resonance imaging scans or physical therapy, without all of the phone calls), credentialing and enrollment of providers was carried out at the national level, standardized methods of reporting were fully implemented, enrollment in public health programs was stabilized, and if there was widespread automation of these processes. As it is now, here in the United States, administration of health care by primarily privately owned insurance companies consumes a huge chunk of our country's health care dollar, and it looks like we will have to continue to deal with the hassle of prior authorization.

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References

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2. Cutler D, Wikler E, Baasch P. Reducing administrative costs and improving the health care system. *N Engl J Med* 2012;367:1875–1878.