SHARE

HEALTH POLICY CORNER: PART II

The Real Cost of Health Care

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Wednesday, September 12, was one of the craziest nights of my residency. I was on call as a second-year resident in internal medicine when a 49-year-old male presented with shortness of breath. He brought his recent echocardiogram results with him, which showed an atrial septal defect (ASD) with severe pulmonary hypertension. Upon arrival at the emergency department (ED), he was hypoxic. Given his history of unrepaired ASD and unknown baseline oxygen status, I was called to admit the patient for pulmonary hypertension, worsening heart failure, and cardiorenal syndrome. During the brief interview, he stated that he had been sedentary and immobile, as his shortness of breath prevented him from taking more than four steps at a time. He also had not been able to work as a landscaper as of late—a job that allowed him to provide for his wife and daughters—because of his worsening disease. The possibility of a pulmonary embolism (PE) was high on my differential. I could not order a computed tomography (CT) angiogram of his chest to rule out a PE because of his history of renal insufficiency. I ordered a heparin drip. However, he soon became tachypneic, tachycardic, and severely hypoxic, requiring intubation, and before the heparin drip could be started, the patient had a cardiopulmonary arrest due to pulseless electrical activity (PEA) and died. My original suspicions were confirmed when I spoke to the coroner's office; the patient had died from a pulmonary embolus.

My patient delayed seeking medical care for one simple reason: He did not have health insurance. Under different circumstances, a primary care physician could have diagnosed his symptomatic ASD and repaired it before it progressed to pulmonary hypertension leading to a PE and death. Unfortunately, the above story is not a rare occurrence. This is the real cost of health care or the lack thereof.

I often see patients repeatedly come to the ED seeking the kind of care a primary care physician should provide. These patients, who we call "frequent fliers," end up using the ED as a primary care physician's office. There is also the story of a 65-year-old man with end-stage kidney disease who routinely arrives twice a week, every month, with recurrent chest pain. He is admitted for chronically elevated troponin levels, and tests are ordered to rule out chest pain. On his last visit to the hospital, a social worker spent two hours with him and his family to discuss compliance. Yet because of the current health care costs and rules that prevent people with existing conditions from getting affordable insurance, he makes repeated returns to the hospital complaining of chest pain and elevated troponin. Here is a patient who continues to overuse resources because he has no primary care physician; it is easier for him to get care in the ED.

The people of this nation decided a long time ago to take care of their own. This is why we have programs like Social Security and Medicare. I believe that it is our responsibility to make quality health care available for everyone regardless of age, gender, and economic or social status. With truly affordable insurance, people can avoid having to utilize EDs as primary care clinics, which taxes our current medical system and drives up costs for hospitals and taxpayers. We can avoid having people wait until the absolute last minute to get the medical attention they need, when it is often too late to make the difference between life and death.

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