Bridging the Gap for the Life Span of Real Healthcare

Healthcare in the United States is a gigantic for-profit business, a market-based industry suited more to maximizing its own profits than dispensing the best possible care to medical recipients. Patients are forced to play the role of consumer while medical industry personnel are forced to watch their bottom lines.

There is a new, hand-picked group of health professionals who know how the system works and how to work the system; experts trained in making connections and resolving the issues that stand between the patient and their optimal state of health. Like visiting a used car sales lot with a mechanic cousin, the group, LifeSpan Care Management, bridges the gap between the patient and the modern American medical monolith, kicking the tires, looking under the hood, and taking a spin around the proverbial block to secure the best possible outcome for their patients.

The New England Journal of Medicine has found that American patients receive proper medical care only 55% of the time,[1] an unacceptable statistic when the patient in question is you or someone you love. "This is the picture of health care in America," says Time Magazine.

"We spend more money than anyone else in the world – and yet have less to show for it than any other developed countries. That's one reason we don't live as long…We encourage hospitals and doctors to perform unnecessary medical procedures on people who don't need them, while denying procedures to those who do…we clog our emergency rooms with patients because they can't get in to see their doctors. We spend more money treating disease than preventing it. We are victims of rampant fraud and over billing. We stand a good chance of dying from a mistake if we are admitted to a hospital, and we kill more people with prescription drugs than with street drugs like cocaine and heroin…Americans tend to believe they have the best health care in the world, but in truth it is a second rate system and destined to get a lot worse and much more expensive."[2]

Deconstructing this predicament, one finds an industry at cross purposes. In an attempt to make their investors wealthy, insurance companies control costs by imposing standardized medical processes upon patients across the board. In an attempt to stay in business, doctors and hospitals must tow the insurance company's line. Also in business to make money are the drug companies, as evidenced by rampant commercialization and the development of questionable

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[1] New England Journal of Medicine, 3/16/2006
[2] Time, 10/11/2004

new symptoms treatable only with superfluous medications. Funded by taxpayer money, government-granted monopolies and FDA-granted exclusivity rights, it is in their best interest to push pharmaceuticals on the public whether needed or not, to replace non-pharmaceutical therapies with medications and to treat symptoms rather than diseases so that their cycle of income continues. The United States government, ostensibly responsible for protecting its citizens, has hardly been a champion for the average health care consumer. In such a mercenary milieu, the patient in modern America stands very much alone.

Even returning war veterans cannot get the care they need and deserve as evidenced by the recent firing of the General in charge of Walter Reed Hospital over deplorable conditions at that facility. The average citizen doesn't stand a chance against the "Corporation" that American healthcare has become, but thanks to LifeSpan Care Management, all that is about to change.

The Doctors

The healthcare system relies on the primary care physician to act as the hub upon which a large wheel turns. Insurance companies, pharmaceutical companies, hospitals, and the Federal Government are just some of the other spokes in the wheel, but the doctor is the common denominator in every interaction between these entities and his patient. Like the relationship between a parent and a child, the doctor must choose the services received, including all testing, the results of those tests, interpretation of those results, prescriptions and their administration, surgeries, referrals, the recommendation of specialists, supervision of progress and a myriad of other healthcare alternatives. Medical records are also maintained and controlled by the doctor's office.

In order to stay in business, the doctor must keep his expenses down, and so he schedules an average of 24 patients in a single working day. According to Francis Collins, director of the National Human Genome Research Institute, the average length of a doctor's visit is now less than 20 minutes, only 16 of which are actually spent face to face with the doctor, during which time they must review the patient's history, conduct a physical exam, order any tests that might be needed, prescribe appropriate drugs or surgical procedures, and schedule the next appointment. In an atmosphere where the doctor's time is so clearly held at a premium, one might feel that any further imposition would place an unnecessary burden and so questions are not asked, issues are not clarified, and complete control rests with the primary care physician, leaving the patient as a passive observer of his own health care.

A New Model of Patient Care: The Healthcare Adovocate

A LifeSpan Registered Nurse Care Manager attends doctor appointments with their patients, lending not only an extra pair of ears, but a wealth of experience and education to the encounter. The patient experience is vastly improved, both in and out of the office, and the physician finds that having a peer participating in the relationship saves them time, reinforces the guidelines and instructions presented, and indemnifies them against malpractice suits. The LifeSpan Care Manager helps the client to become a pro-active member of their own healthcare team, a knowledgeable participant in their own well being, while at the same time keeping down costs and improving outcomes.

A LifeSpan Advocate allows the patient and their family/support system to make decisions that take into account their own value system and to evaluate the kinds of chances they are willing to take in the course of their own care. Because their clients are uniquely well informed, caregivers at the doctor's office or the hospital will not have to guess if the LifeSpan patient wants to prolong life at any cost, withhold heroic measures, undergo extensive testing to rule out every possibility, or any other process that falls within the category of informed consent. Although the Kaiser Family Foundation reports that 60% percent of seniors surveyed stated that they understood their options "not too well" or "not at all," LifeSpan clients of all ages have a Registered Nurse Care Manager at their side to see that their previously disclosed wishes are fulfilled. LifeSpan educates and advocates for patients who have intricate and complex medical decisions to make, are extremely ill or face insurance companies resisting compensation.

In addition to the counseling and advocacy aspect offered to clients, LifeSpan has developed a technologically supported counseling and advocacy service that steps into the breach left by the declining influence of the family doctor. The aptly named GuardianKey™ is a password protected, encrypted USB Flash Drive onto which an individual's medical records are downloaded. The information on the GuardianKey™ is accessible only to those individuals designated by the patient. In an emergency event in which the patient cannot speak for himself, the flash drive is plugged into any computer, and the initial screen appears and directs the viewer to call an 800 number connecting him with LifeSpan. From there, the LifeSpan Care Manager gives the caller an alpha-numeric key that unlocks the system and guides the caller through critical health information.

The patient's information is stored not only on the flash drive, but on an encrypted and password protected database accessible in LifeSpan's numerous offices. If the flash drive is misplaced or stolen, if there is a fire or some other crisis, retrieving the patient's information is fast and easy.

Some of the essential information that might be stored on a GuardianKey™ are medical records, medications, x-rays, scans, living will and other legal documents, insurance cards, policies and information, house and car deeds, photographs of family heirlooms, passport, birth and marriage certificates, credit cards, tax returns, banking records, contact information for family and professional councilors, and even pet information.

In an article entitled, How to Prepare for One Really Quick Getaway, the New York Times advises readers to utilize a flash drive and upload all of their pertinent information because in the project of rebuilding your life in the chaos following a disaster, if you have a comprehensive record, "you go to the front of the line."[3]

The Insurance Companies

Thousands of different insurance companies, each with their own paperwork requirements, coverage and payment rules, force doctors and hospitals to act as administrators, increasing overhead costs for everyone involved. Other industrialized countries deal with a single insurance plan and one standard claim form; citizens can opt to upgrade at their own expense. Because the care received by the average insured American is not even close to being commensurate with the expense of supporting such an expansive bureaucracy, the services offered by LifeSpan Care Management are essential.

A landmark 2005 survey comparing U.S. healthcare with other western countries published in the journal *Health Affairs* found that, "Americans were the most likely to pay at least $1,000 in out-of-pocket expenses. More than half went without needed care because of cost and more than one-third endured mistakes and disorganized care when they did get treated." The survey went on to say that Americans stood out for having the highest error rates, the most disorganized care and the highest costs. 50% of Americans said that they had decided not to fill a prescription, to see a doctor when they were sick or against getting recommended follow-up tests. One-third of U.S. patients reported problems with the coordination of their care, such as test results not being available when they arrived at a doctor's appointment or doctors ordering duplicate tests. Thirty-four percent reported getting the wrong medication or dose, incorrect test results, a mistake in their treatment or care, or being notified late about abnormal test results.

Money is saved when non-essential and/or unsatisfactory care is replaced with high quality care. Exceptional care *is* cost effective.

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[3] The New York Times, October 1, 2005

A 2004 study in the International Journal of Health Services finds that health care bureaucracy cost the United States $399.4 billion in 2003, or 4.3 times the amount spent on national defense. As the business of healthcare grows, the cost of health insurance has increased. In 2004, health care spending in the United States reached $1.9 trillion; it is projected to reach $2.9 trillion in 2009 and $4 trillion by 2015. Other industrialized countries don't even come close to these figures, but the runners-up all subsidize their citizen's healthcare in full. In 2004, the United States spent 16 percent of its gross domestic product (GDP) on health care. It is projected that the percentage will reach 20 percent in the next decade.

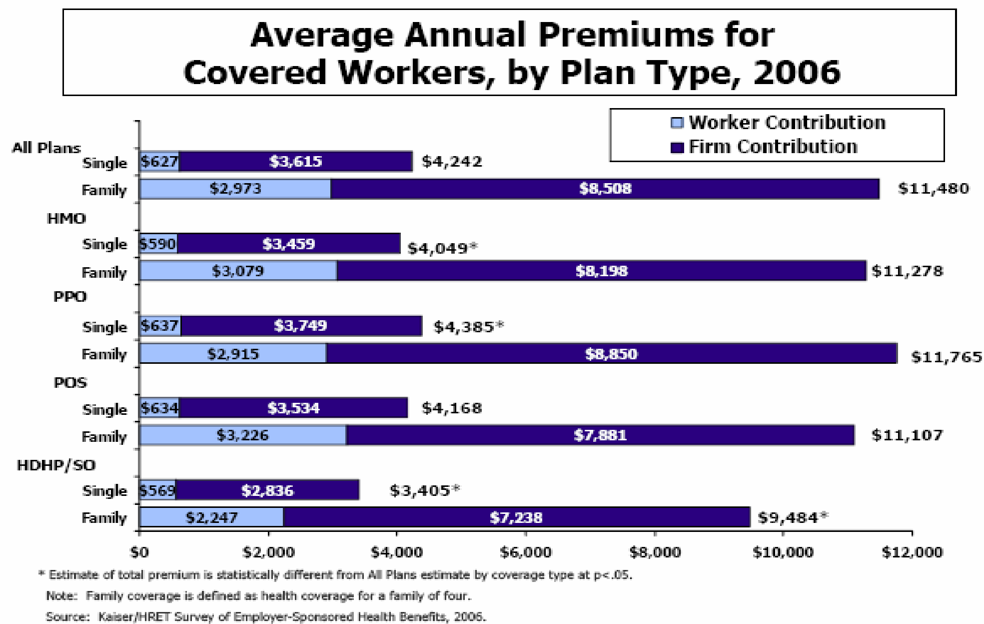
Americans pay out the majority of their annual expenses on healthcare but receive less than stellar service in return. According to the United States Department of Commerce, a 2006 study revealed that Americans spend the majority of their annual incomes as follows:

#1 Expense:	Medical Care
#2:	Housing
#3:	Food
#4:	Home Operations *(heat, hot water, property insurance, etc.)*
#5:	Automobile
#6	Other

According to CreditCard.com, most credit card debt of older Americans is driven by healthcare expenses and the increased cost of prescription medication.

A UPI/Zogby poll says that even those individuals with annual incomes of $75,000 and more think twice about collecting the medical benefits to which they are entitled, despite the fact that a portion of their wages are deducted from their paycheck to cover health insurance costs!

According to the Henry J. Kaiser Family Foundation, the annual premium that a health insurer charges an employer for a health plan covering a family of four averaged $11,500 in 2006. Workers contributed nearly $3,000, or 10 percent more than they did in 2005. The annual premiums for family coverage significantly eclipsed the gross earnings for a full-time, minimum-wage worker ($10,712), rising four times faster on average than workers' earnings since 2000. The breakdown of payment is as follows:



The Henry J. Kaiser Family Foundation

According to Hewitt Associates LLC, the average employee contribution to company-provided health insurance has increased more than 143% since 2000. Average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose 115% during the same period**.**

Billing errors are rampant. Hospitals alone overcharge patients an estimated $10 billion a year for services never rendered, coding mistakes, charging for a more expensive procedure than was performed and duplicate charges. There are no federally mandated standards in the medical billing industry, so hospitals, pharmacies and doctor's offices interface with 30+ insurance companies, Medicare and Medicaid, their respective billing systems and payment requirements. Personnel with the Medical Billing Advocates of America say that they find multiple errors in 8 out of 10 hospital bills reviewed.

"A market-based system distributes health care as a commodity according to the ability to pay, instead of as a social service distributed according to need. Yet, there's an inverse relationship between one's ability to pay for health care and one's medical needs. The situation gets crazier when you allow competing, investor-owned insurance companies to insure Americans, because they have learned that the best way to compete is to keep costs down by skimping on health services. We have the only health care system on the world that's based on dodging sick people. [Insurers] do everything they can to avoid covering people at high risk of getting ill, and when they do get ill, [companies] fight paying for it. They exclude certain expensive conditions as much as possible. They pass

those costs back to the patient or another insurer. And that takes a lot of paperwork, and a lot of overhead."[4]

According to the Washington Post, the system works like this: "Hospitals grant volume discounts to private insurers. In return, the insurers place the hospital on a preferred list of providers and steer millions of patients to them…But consumer advocates say insurers don't have the time or wherewithal to review bills line by line. Content with the discounts they receive, they say, insurers pay immediately and let the less egregious errors slip through the cracks rather than risk damaging their relationships with the hospitals."

"LifeSpan clients get their money's worth and then some," says Mike Newell, President and CEO of LifeSpan Care Management. "We negotiate, in advance, for the services and products needed, whether in a hospital or an at-home setting. We know going in that a box of tissues in your hospital room can cost $60 (bring your own!), what medical equipment will be needed in the Operating Room or the living room and how much those things should cost, and how to check the anesthesiologist's record to make sure that you're charged for the correct amount of time in surgery.
Your Care Manager can actually read your bill and understand each and every charge, distinguishing fact from fiction and saving you and your insurance carrier both time and expense.

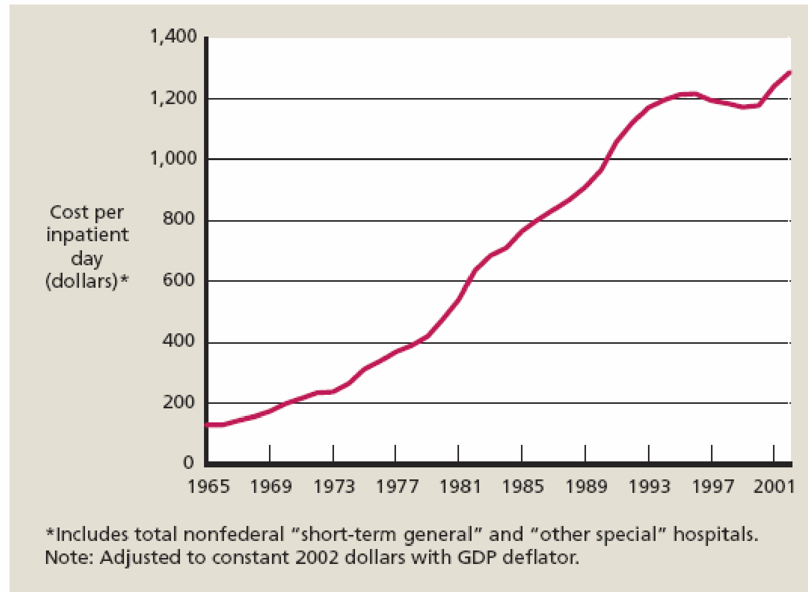
The Hospitals

The Hospital Quality Alliance assessed how 3,558 American hospitals performed based upon ten quality indicators shown to reduce death or improve health and found that for six of the ten indicators, patients failed to receive needed care about 10 to 20% of the time. For the other four indicators, performance was even worse. In other categories the research showed that not-for-profit hospitals consistently had significantly higher scores than for-profit hospitals, and that hospitals in the Northeast and Midwest outperformed hospitals in the West and South.

A groundbreaking 1999 report by the Institute of Medicine found that up to 98,000 Americans die every year from preventable medical errors made in hospitals alone. There are more deaths in hospitals each year from preventable medical mistakes than there are from vehicle accidents, breast cancer, and AIDS. The American College of Physicians estimates that by the year 2015, 150 million Americans will have at least one chronic health condition. At the same time, the U.S. Department of Health & Human Services states that 20 million American children currently suffer from at least one chronic condition. This sad state of affairs is exacerbated by the common knowledge that hospitals are dangerous

[4] Dr. Marcia Angell, (former editor of the New England Journal of Medicine), Mother Jones, 3/21/2004

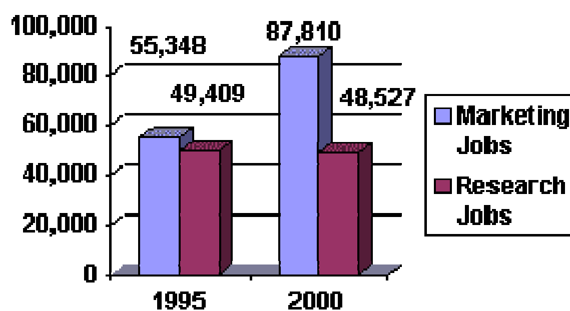
places, drug firms have created a culture in which there is a "pill for every ill," and insurance companies are saving money by cutting corners at the expense of the patient.



LifeSpan Registered Nurse Care Managers come from the hospital trenches and understand what their patients are up against. As a result, these R.N.s are singularly equipped to shepherd clients safely through the hospital experience, completely avoiding it whenever possible.

Pharmaceutical Companies

The top ten pharmaceutical companies make more in profits than the rest of the Fortune 500 combined. Considering that they spend 2.5 times as much on marketing and administration as they do on research and development discredits the picture that they paint of themselves as a noble industry largely subsisting on crumbs while their research and development departments gorge on the rest of the feast.



From AMSA.org, the website of the American Medical Student Association

Meanwhile, a large part of the Federal Drug Administration's budget is made up of "user fees," paid by the drug companies, to the tune of about a half a million dollars for each drug the FDA reviews. It is a conflict of interest for the Federal watchdog agency responsible for protecting its citizens to be funded by the industry it's meant to regulate. According to the Center for Public Integrity, the pharmaceutical and health products industry has spent more than $800 million in federal lobbying and campaign donations at the federal and state levels, since the late 1990s. "Its lobbying operation, on which it reports spending more than $675 million, is the biggest in the nation. No other industry has spent more money to sway public policy in that period. Its combined political outlays on lobbying and campaign contributions are topped only by the insurance industry."

Company	**Marketing costs**	**Research and Development**
Pfizer	$16.90 billion	$7.68 billion
GlaxoSmithKline	$12.93 billion	$5.20 billion
Sanofi-Aventis	$5.59 billion	$9.26 billion
Johnson & Johnson	$15.86 billion	$5.20 billion
Merck	$7.35 billion	$4.01 billion
Novartis	$8.87 billion	$4.21 billion
AstraZeneca	$7.84 billion	$3.80 billion
Hoffman La Roche	$7.24 billion	$4.01 billion
Bristol-Myers Squibb	$6.43 billion	$2.50 billion
Wyeth	$5.80 billion	$2.46 billion
Abbott Labs	$4.92 billion	$1.70 billion

From publicintegrity.org

The pharmaceutical companies are privately held, multi-national corporations, and, as such, are in the business of making money, mostly on the shoulders of the American public. Other industrialized countries subsidize their citizens' healthcare, so insist that drug prices are kept in check, while the patients of this country are bilked for higher prices than anywhere else on earth and kept in a state of fear. Why should it be that a company with manufacturing plants in more than 50 countries across the globe should declare drugs coming out of Canada dangerous and beyond the scope of regulation? Shouldn't one, then, be wary of any drug manufactured outside of the United States and imported over international borders?

In fact, approximately 86% of all drugs sold in the U.S. are manufactured outside of our borders. Among the most popular, Prevacid, is produced in Japan, Lipitor and Viagra are produced in Ireland and Nexium comes from Sweden and France.

While there *are* legitimate miracle drugs, one would be wise to be skeptical of an industry that prescribes the lion's share of its cures for indigestion, erectile dysfunction, high cholesterol and other important problems that are just as easily cured - for free and without medication of any kind - with simple changes in diet and behavior. A LifeSpan Care Manager knows that the old adage about an ounce of prevention being worth a pound of cure is true.

Healthcare "System?"

Faring well in the healthcare system is simply about managing information and making the right connections: between the patient and their body, the patient and their doctor, the doctor and the specialists, the doctor and the hospital, the hospital and the insurance companies, the hospital and the patient. In the words of the U.S. Department of Health & Human Services, "The health care "system" in America is not a system. It's a disconnected collection of large and small medical businesses, health care professionals, treatment centers, hospitals, and all who provide support for them. Each player may have its own internal structure for gathering and sharing information, but nothing ties those isolated structures into an interoperable national system capable of making information easily shared and compared.

Interoperable systems are invisible but essential. We have come to depend on many. When you use a cell phone to talk with a friend who uses a different cell service, you are using an interoperable system. Your ATM card is good not only at virtually all banks nationwide, but thanks to a secure interoperable system, you can use it to buy everything from groceries to gasoline.

These systems work because the telephone and banking sectors have developed methods and standards that allow participants in their systems to easily access and exchange information while the companies operate independently and compete vigorously.

Cell phone providers are keenly aware of their competitor's quality of service. Banks closely monitor competitive rates. Customers are able to compare both quality and cost. Value-driven consumer choice, in turn, drives greater competition and increasingly better service."[5]

[5] From the United States Department of Health & Human Services website. www.hhs.gov/transparency

In the not too distant past, the primary care physician shepherded generations of family members from cradle to grave, providing a continuum of care that spanned entire lives. The doctor really knew his patients, their parents, and children who were all members of an extended and familiar community.

In the modern world, one is a co-payment, a medical record, a credit card number. The patient doesn't know their names and they don't know the patient's, much less their values, personality, risk aversions and health goals. Care is based less upon the individual than upon precedents set by those who came before, in a kind of a care management by majority rule. The healthcare machine can only make money by getting each patient through the system as quickly as possible. They do this by pushing everyone through the same slot, regardless of their particular dimensions. LifeSpan Care Managers are dedicated to slowing down the behemoth, to giving their client a voice, making sure that they know what they need to know to get what they want, to get the best of everything available, to ensure that they understand what is happening and why, to act as a gate keeper in assuring the best utilization of insurance resources, available family funds, physicians, hospitals, nursing homes and other facilities. LifeSpan wants their client to have what they deserve:

The best possible healthcare.

For more information, contact:

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