

## Office Hysteroscopy & Healthcare Efficiency

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Cost-efficiency is one of the essential attributes of a highly-performing healthcare system. Over the years, health care has undergone progressive leaps that lead to a storm of overutilization and increasing cost.<sup>1</sup> In 2001 the Institute of Medicine (IOM) called upon the healthcare system to focus on safe, timely, effective, efficient, equitable, and patient-focused care.<sup>2</sup> Yet evidence is compelling that the health care system is far from being efficient. According to the World Health Organization, the United States (US) ranks only 37<sup>th</sup> among world countries in overall health care system performance.<sup>3</sup> Certainly this low rating should be looked at with concern but we remind that people from around the world, even from countries with more efficient systems, come to the US because of our excellent healthcare services - if they can afford to pay for them.

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Healthcare providers can play a very decisive role in defining healthcare efficiency by fostering a positive

dialogue with payers and patients and actively engaging in drafting healthcare policies. The US healthcare system proclaims excellence but we need to take full advantage of the potential synergy between efficiency and quality.<sup>4</sup> Thus, our most pressing task at this moment is to decrease healthcare cost without affecting quality, delaying access, or stifling innovation. In this paper, we put forth an example of inefficient care in gynecological practice and try to suggest solutions for the rampant bureaucracy in the current healthcare system.

Taking office hysteroscopy as an example, the literature attests to its high success rate and low complication rate, but fewer than 20% of gynecologists perform hysteroscopy in their offices.<sup>5,6</sup> In our practice, we have been performing hysteroscopy with D & C (dilatation and curettage) as an office procedure for over twenty years. Over a thousand patients have undergone office hysteroscopy uneventfully. Patients are given minimum anxiolytics and paracervical-parametrial blocks and generally tolerate the procedure well, similar to having a dental procedure.

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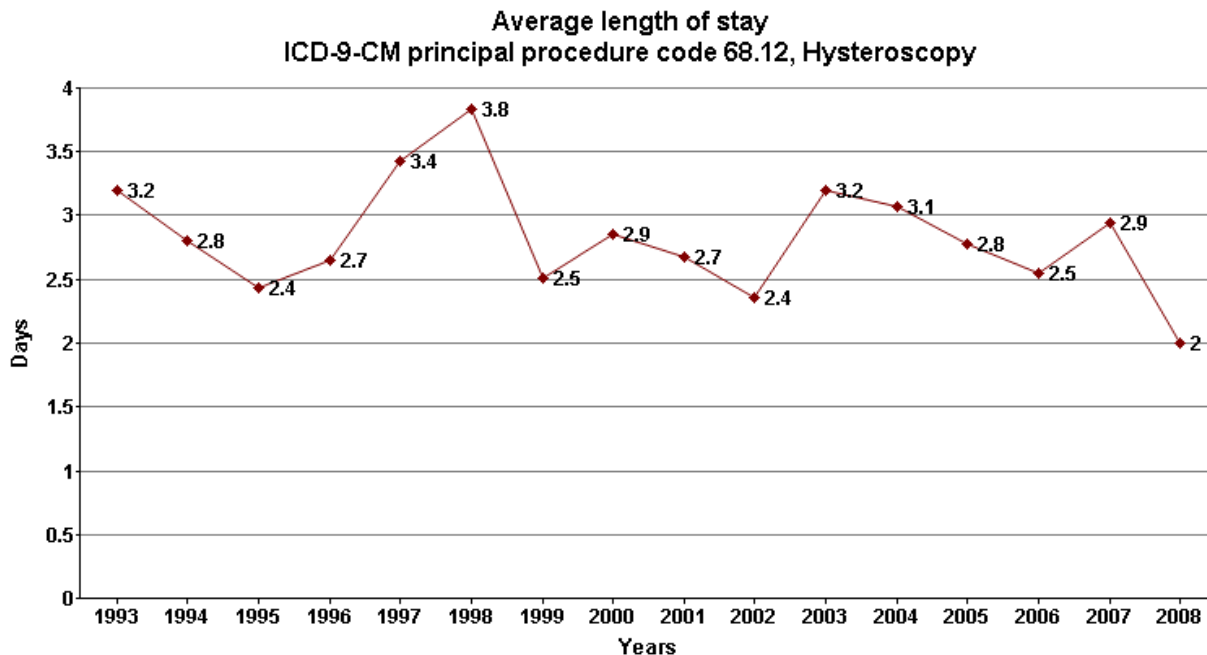
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Only 2% of the patients we have cared for required an in-hospital procedure, mainly due to increased cardiovascular risk. Only two cases were admitted to the hospital for overnight observation, both related to uterine perforation. Thus, the overwhelming majority of cases were treated without any significant complications and at substantial cost savings.

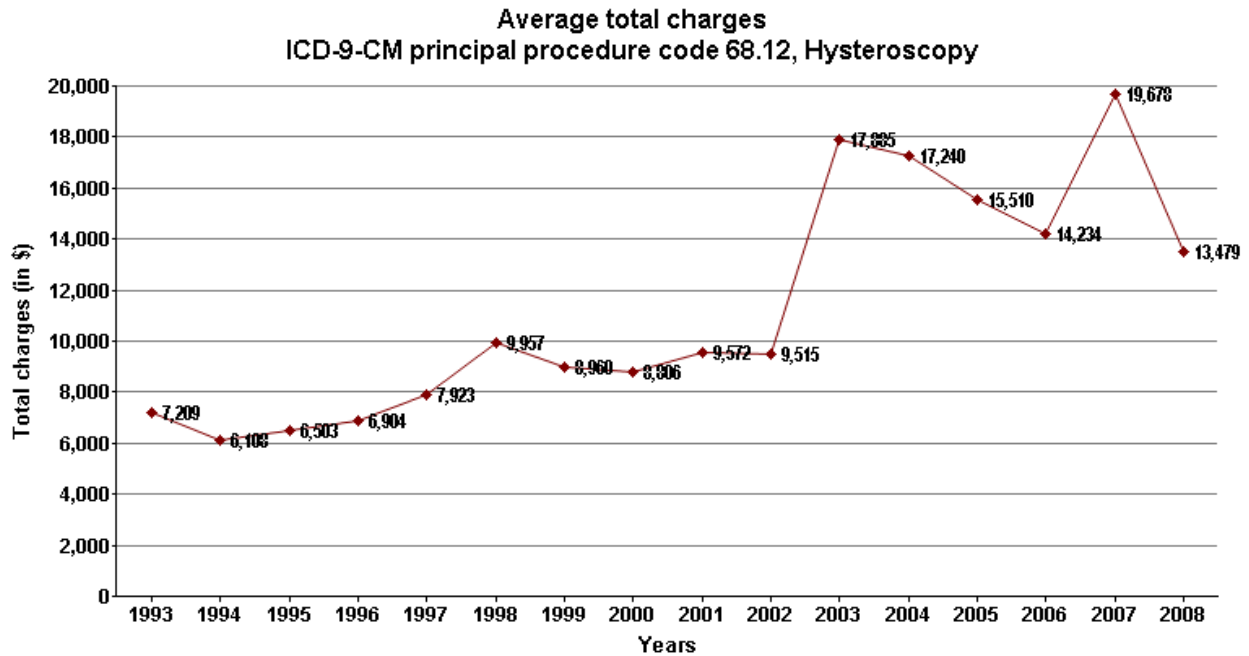
From our experience, we believe that hysteroscopy has little place in the hospital; it should be an office procedure. There is no incentive for physicians, however, to convert hysteroscopy to an office procedure. The reason for this relates to the practices of the insurers and the protectionist nature of hospitals which

seek to retain profitable surgical procedures, potentially to the detriment of the system.

Length of hospital stay for inpatient hysteroscopy has decreased over the last two decades (Graph 1). However, the cost of inpatient hysteroscopy has actually increased (Graph 2). Current charges total between \$14,000 and \$15,000 per case, and actual reimbursements vary between \$8,500 and \$9,500. As an inpatient procedure, this cost is driven by charges from anesthesia, the operating room, nursing, the recovery room, etc. In contradistinction, when hysteroscopy is performed as an office procedure, the payment is only the physician part, approximately \$400, and the practice is not reimbursed for the equipment, personnel, and supplies.



**Graph 1** shows length of hospital stay information from the period 1993-2008 for inpatient hysteroscopy as a primary procedure. Source: Healthcare Cost and Utilization Project (HCUPnet) Available at: <http://hcupnet.ahrq.gov/>.



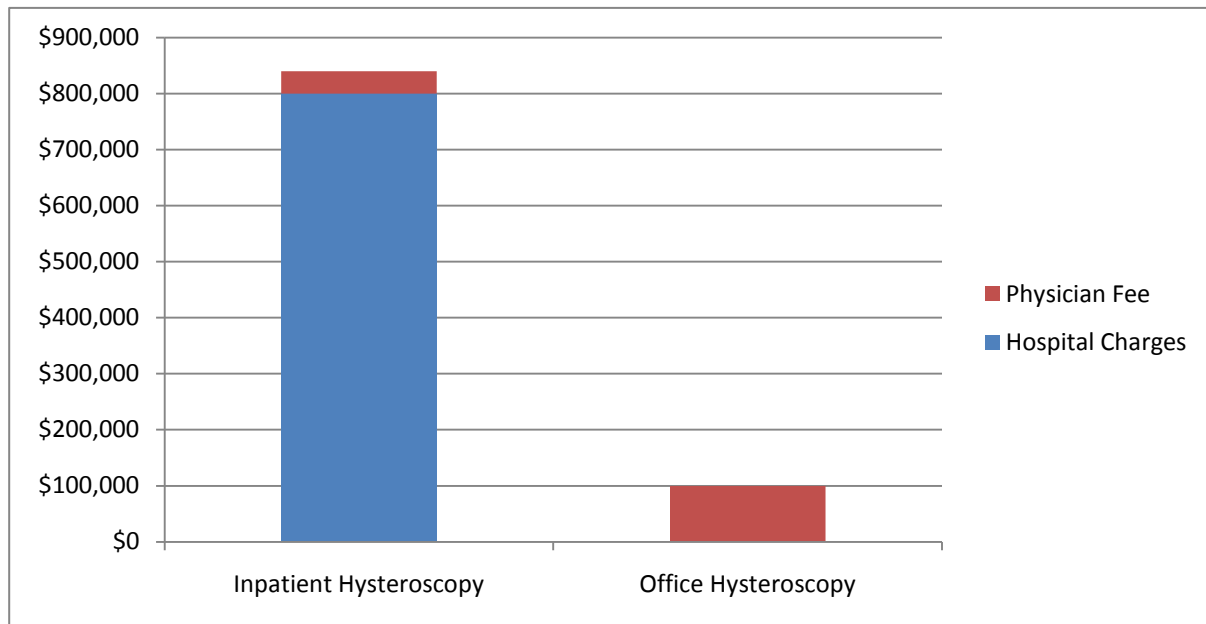
**Graph 2** shows hospital charges information from the period 1993-2008 for inpatient hysteroscopy as a primary procedure. Source: HCUPnet. Available at: <http://hcupnet.ahrq.gov/>.

If insurance companies were to double the payment for office hysteroscopy as opposed to continuing to pay for more expensive hospital hysteroscopy, the number of office cases would increase substantially, and resources could be saved.

The principle cause of high US health care costs is the failure of the third party payor system to provide sufficient incentives to providers (physicians and hospitals) to be value-conscious in the management of their clients (patients) and to promote the rational use of

healthcare resources.<sup>7</sup> Practices which perform office hysteroscopy have saved the healthcare system substantial resources over the years, yet physicians are not rewarded for these cost savings.

An example is shown below, demonstrating the theoretical savings accrued for 100 hysteroscopies performed in the office compared to the hospital. Even with our proposed increase in reimbursement to physicians, allowing them to adequately cover their costs, the savings are remarkable (Graph 3).



**Graph 3** depicts the amount of money saved for the healthcare system if 100 hysteroscopies were performed in inpatient vs. office setting with the following assumptions:

- Inpatient hysteroscopy: Insurance pays the hospital \$8,000 and the physician \$400.
- Office hysteroscopy: Insurance pays the hospital \$0 and the physician \$1,000.

The difference = \$740,000.

If healthcare is to be readily available to the public at a cost that is acceptable to the provider, we think that free market medicine should be implemented. Why does the food cost remain so low? Why do so many other things cost so little? It is because we let the market decide the price. Unfortunately in medicine, the government, the insurance companies, the lobbies and hospitals decide what procedures and supplies will be paid for and where the procedures should be performed. Technology and the free market work efficiently in many service industries; we believe it would work in medicine as well.

Other examples in the field of obstetrics and gynecology abound: if insurers want to drop the cost of care, why do

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they uniformly refuse to incentivize performing minor procedures such as Essure® insertions and endometrial ablations in physician offices. We would do mini-slings in our office, but insurers will not pay us for the slings. LEEPs (loop electrosurgical excision procedures), Bartholin marsupialization, vulvar biopsies, excision of hydradenitis of the vulva, etc, are other examples. None of these procedures are rewarded for the cost savings of keeping them in the office. Just think how many other procedures with improved technologies could be safely office-based if properly reimbursed both in our specialty and in other specialties.

Reintroducing free market principles with proper regulation and preventing

insurance monopolies have the potential to drastically reduce costs, just as these principles have functioned in other markets. Competition between providers and improvement in technology will drive costs down in medicine, just as in other service industries. Technology linked with provider competition will lead to the transfer of many procedures to the doctor's office and away from high cost, inefficient and bureaucratic hospitals.

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