VIEWPOINT

"Financially Palliative": The Need to Address a Perplexing Financial Conundrum in Emergency and Critical Care

Rachana Bhat[1], Akshaya Ramaswami[2]

Abstract

The terminology "Financially Palliative" is a pseudonym and refers to a unique challenge faced in countries where public healthcare insurance coverage is not robust and the percentage of out-of-pocket health expenditure continues to be high. Emergency and critical care healthcare expenditures in such circumstances usually pose additional burden as they are unforeseen expenses, disproportionately high, for which most people are unprepared. Such situations may lead into a vicious cycle that initiates with expenditure hesitancy and delay in definitive care, which in turn leads to deterioration in the patient's condition and delay-related complications. This further fuels expenditure hesitancy due to uncertain prognosis and outcomes. The future threats posed by this issue are manifold, which are not only restricted to poor patient outcomes and diminishing physician morale but also hinder progress in science by influencing research outcomes/endpoints in areas where it is highly prevalent. Identifying and defining the problem with terminology is only the first step in working towards solutions. The issue needs to be addressed and mitigated before it spreads its roots deeper into our healthcare system.

Keywords: Catastrophic expenditure, Cost-effective care, Healthcare expenditure.

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Highlights

Emergency and critical care bears high unforeseen healthcare expenditures for which most people are unprepared. This might cause an initial expenditure hesitancy, thereby leading to a vicious cycle of delay in definitive care, delay-related deterioration, and increased overall healthcare costs, fueling further expenditure hesitancy. This concept with the pseudonym 'Financially palliative' may have an impact on overall patient outcome, healthcare metrics, research endpoints-outcome, and the moral-ethical mindset of the treating doctor.

Introduction

The scope of palliative care is rapidly expanding in our subcontinent, encompassing a wide spectrum of diagnoses ranging from acute to chronic conditions. The uniqueness of palliative care lies in its core essence of care that is directed not only to patients but also to their families to improve their overall quality of lives.

The terminology 'Financially palliative' is a pseudonym and does not reflect the true nature of palliative care. It is coined to address a unique challenge in countries, particularly in Southeast Asia, where the majority of patients are not covered by health insurance. The percentage of GDP expenditure for health in India is around 2%, and out-of-pocket health expenditure still ranges between 45 and 60%.[1] Emergency healthcare expenditure, followed by the direct and indirect costs of intensive care[2] poses additional burden in situations such as polytrauma, cardiac arrest, or severe infections requiring ICU care where most families are not prepared for the disproportionately high and unforeseen expenses. These situations are also the cause of catastrophic health expenditure, ranging from 16.5 to 64.7% in public and private health systems in Southeast Asia.[3]

[1]Department of Emergency Medicine, Kasturba Medical College, Manipal Academy of Higher Education, Manipal, Karnataka, India

[2]Department of Emergency Medicine, All India Institute of Medical Sciences, New Delhi, India

Corresponding Author: Rachana Bhat, Department of Emergency Medicine, Kasturba Medical College, Manipal Academy of Higher Education, Manipal, Karnataka, India, Phone: +91 9599460465, e-mail: Rachana2806@gmail.com

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Discussion

To delve deeper into understanding this concept, we can categorize emergency health expenditure under the following patterns (Fig. 1).

Pattern A expenditure occurs in diseases such as myocardial infarction, where the disease can be critical and with scope for immediately implementable treatment modalities, following which the patient can recover close to normal. A delay in presentation or a complication in such cases usually leads to early death. The expenditure pattern here in either of the patient outcomes is a huge spike and an almost rapid return to normality. Since the treatment modality here raises hope for a near-normal recovery and is mostly one-time, the expenditure hesitancy is minimal.

Pattern B expenditure occurs in conditions such as road traffic injuries with fatal or near-fatal injuries, where the patient reaches the health system and initial resuscitation attempts are unsuccessful or, if successful, the nature of the injuries is such that further resuscitation

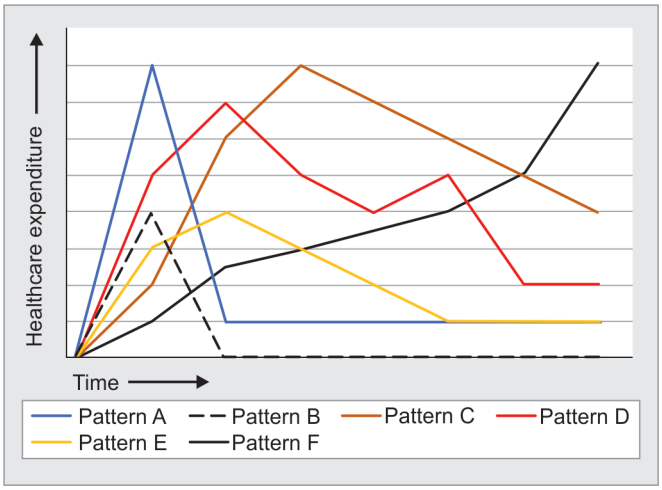

Fig. 1: Healthcare expenditure vs time trajectory patterns

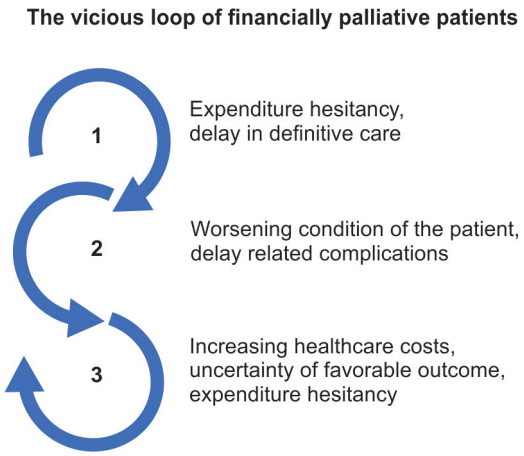

Fig. 2: Vicious loop of expenditure hesitancy

is clearly futile. For example, road traffic injury with severe head injuries and tonsillar herniation with absent brainstem reflexes. Resuscitation in the emergency department (ED) is a resource-intensive process, both in terms of financial and other resources. In such cases, while it is emotionally stressful for the family to deal with the sudden loss of a family member, financially the pattern of health expenditure is a small spike and a return to baseline.

Pattern C expenditure occurs in cases such as polytrauma with multiple orthopedic injuries. The patient may initially present to the ED in critical condition due to extensive hemorrhage, require time-sensitive resuscitation. However, after resuscitation and stabilization, the road to recovery is lengthy and involves multiple phased surgeries and rehabilitation. The trajectory to recovery may be longer if complications such as secondary hospital-acquired infections or deep vein thrombosis occur. Healthcare expenditure in such cases will go from high to higher and then reach a plateau. A large amount for initial ED resuscitation, a larger one for further surgical interventions, and a lower plateau for further recovery and rehabilitation.

Pattern D expenditure occurs in cases where resuscitation is difficult, costs are high, and the course of recovery and outcomes are uncertain, such as in patients with septic shock with multiple organ failure or polytrauma with neurotrauma or solid organ injuries.

Pattern E expenditure occurs for potentially critical diagnoses that are identified and treated in a timely manner before complications arise. This is an ideal trajectory of care and expenditure for any patient.

Pattern F is the expenditure pattern that may be the entry point into the "financially palliative" pathway. It starts with a semicritical or critical diagnosis where the cost of definitive care cannot be borne by the patient or their relatives. This leads to a vicious cycle that starts with expenditure hesitancy and delay in definitive care, which in turn leads to deterioration in the patient's condition and delay-related complications. By the time the patient/family raises the necessary funds for treatment and accepts the definitive treatment plan, the outcome is uncertain due to complications related to the delay in treatment, which in turn fuels the thought of expenditure hesitancy, thereby leading to poor outcomes for the patient (Fig. 2). Examples might include a case of stroke where the window of opportunity for thrombolysis is missed, a patient with acute renal failure where early dialysis is delayed, an acute myocardial infarction where revascularization is delayed, or a patient with polytrauma or sepsis where initial resuscitation and stabilization are inadequate. In addition, Pattern E patients may enter this pathway whenever the hospital treatment takes an unforeseen course, such as secondary deterioration due to hospital-acquired infections. This is in contrast to cases of malignancy, where the diagnosis itself sets up the patient's caregivers for higher treatment costs and uncertain or unfavorable outcomes.

It is important to recognize, mitigate the problem, and find solutions to minimize this subset of "financially palliative" patients. The future threats posed by this issue are manifold. The financial constraints of the patient's family can be passed on, placing the attending physicians in a moral dilemma that leads them to pursue cost-cutting strategies in care. Delay in definitive care or life-saving surgery can lead to complications requiring prolonged stays in the ICU, prolonged life support measures such as mechanical ventilation and renal replacement therapy, an increased incidence of hospital-acquired infections, and the need for expensive antimicrobial therapy, thereby increasing overall healthcare costs for the system and caregiver. These uncertain patient outcomes lead to poor healthcare metrics, which can lower the morale of treating physicians. Such care becomes a financial sink with an uncertain outcome for both the patient's family and the health system, making it economically unviable for both the system and the patient's family and driving the system to abandon the treatment halfway through. This malignant development drives these patients towards futility of care that is not futile in the true sense, and this forms the crux of the term "financially palliative". Such patients are usually recorded in the system as "discharge against medical advice" (DAMA).[4] DAMA patients can additionally hinder progress in science by influencing research outcomes/endpoints, contributing to poor metrics, demotivating clinicians, and deterring them from making apt treatment decisions with only financial implications in mind.

Conclusion

Holistic, value-based, and personalized care that takes into account the social, cultural, and financial implications of treatment is the virtue of any clinician. However, this is an issue that can put the best doctors in a moral and ethical conflict when delivering treatment in critical situations. Identifying and defining the problem with

terminology is only the first step in working toward solutions for the problem. The issue needs to be addressed before it further spreads its roots deeper into our healthcare system.

Orcid

Rachana Bhat https://orcid.org/0000-0003-2141-5531
Akshaya Ramaswami https://orcid.org/0000-0002-1683-9658

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