

Critical economics of life and death: Intense + Expensive care = Intensive care?

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Healthcare costs are increasing globally. A deliberate attempt to formally introspect and being prudent in controlling the costs are essential, particularly in resource-limited settings serving a price-sensitive population.^[1]

Inpatient hospital expenditures in the “last year of life” account for 27–31% of Medicare expenses in the United States.^[2] While Medicare predominantly covers the elderly, it is probably appropriate to extrapolate this data to all non-survivors in the Critical Care Units (CCU) who spend a significant proportion of their lifetime healthcare expenses during their last hospitalization, particularly for services provided in the Intensive Care Unit (ICU).

In this issue of IJCCM, Shweta Kumari *et al.* have explored the costs associated with care in a Respiratory Critical Care Unit (RICU) in a tertiary care hospital. While some of their results such as length of stay being higher in non-survivors, variable costs being higher on Day 1, and drug costs contributing to significant proportion of overall variable costs are intuitive and acceptable, a few other findings require closer evaluation.

It is important to take note of the fact that the study was done in a teaching hospital with trainees, which was probably why the doctor to patient ratio (1:4) was much higher than what is usually prevalent. However, the average nursing ratio of 1:2 is less than usual, considering that a significant proportion of the patients were ventilated. Interestingly, ICU personnel work harder (higher Therapeutic Intervention Scoring

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System (TISS) scores) and longer (length of stay) for non-survivors. This is akin to the findings of Lee *et al.*^[3] who analyzed the cost and outcome of cardiopulmonary resuscitation (CPR) and concluded that it is expensive to cheat death. They encouraged appropriate CPR and suggested to exercise caution in widespread application as it is expensive.

Of particular note is the fact that the study was conducted in a not-for-profit, central government funded, autonomous tertiary care center, and charges were subsidized and fixed arbitrarily. The authors have appropriately mentioned this as a limitation as it may be inappropriate to extrapolate the information to all ICUs in a country like India with diverse ICUs with a predominance of private facilities providing critical care to a significant proportion of the population.^[4] ICU designs, physician staffing, and reimbursement models are widely variable within India^[5] and may be the driving factors of cost and charges.

The observed mortality rate (18.98%) in this study is lower than what is quoted in other Indian studies.^[6] The delta Sequential Organ Failure Assessment (SOFA) score was found to have a positive relationship with in-hospital mortality. The authors attribute improved survival to less number of elderly patients and overall improved management of critically ill

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patients over the years since publication of earlier studies quoting higher mortality rates. While the mortality rate was less, the reality is that it was more intense and expensive to provide intensive care to these individuals.

Altruistically, I quote Sir William Osler, "The practice of medicine is an art, not a trade; a calling, not a business: a calling in which your heart will be exercised equally with your head." However, realistically, I would like to modify Benjamin Franklin's statement, "God heals and the doctor (*Hospital*) takes the fees." Yes, as intensivists, we adhere to Hippocrates' principles and cure sometimes, treat often, comfort always – but at what cost?

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