Choosing Wisely

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Health care continues to be our biggest domestic policy challenge and recently provoked a federal government shutdown and debt ceiling crisis. United States health care funding has steadily risen from 5% of the gross domestic product (GDP) to today's 17.5% GDP.[1] How should we proceed to reduce these costs and avoid future budget crises? The solutions will not be easy and will require more efficient delivery by providers and lower expectations from consumers.

The recent government shutdown was staged to delay or cancel the implementation of the transformative but controversial Patient Protection and Affordable Care Act (PPACA). The PPACA represents a major change in our health care delivery system by offering or requiring health insurance to individuals who previously could not access or afford insurance. Previous major social service transformations also led to shutdowns after the introduction of Social Security and Medicare. Despite these protests, these services have gradually become institutions in the United States, and it is likely that the PPACA will become an institution as well.

Will the PPACA reduce our health care spending enough to make everyone happy? The PPACA introduced several ways to help reduce costs. The first-year results of the government-administered Pioneer Accountable Care Organization (ACO) Model showed up to a 4.6% reduction in total cost of care for Medicare patients in northeastern Wisconsin, with an overall savings of $87.6 million.[2] However 12 of 32 ACOs lost money and 9 will exit the Pioneer program. These cost savings are not enough to reduce the budget deficit.

What models do show a more substantial reduction in health care costs? Health care costs are much lower in many countries in the Organization for Economic Cooperation and Development (OECD). They average 6% to 12% GDP and maintain similar age-adjusted mortality rates and improved life expectancies compared with the United States. The United Kingdom and Canada provide universal health care coverage with single government payers. Consumers in these countries have accepted longer waits for procedures and reduced access to expensive procedures. To reduce health care costs, these countries can restrict redundant facilities and prevent unnecessary procedures. Not all US states have a high health care cost. California demonstrates lower health care costs; it has the ninth lowest US per-capita spending with hospitalization days and hospital admission rates of 74% to 79% of the national average. This low rate was achieved with 78% of expenditures paid under fee-for-service plans.

What does this mean? The PPACA may improve access to care but may not be the magic bullet to significantly reduce health care costs. We will need to look to California and other OECD countries to find better models for acceptable care at affordable prices.

Do we want or need economy class health care? We may not want to downgrade from our first-class access but we may be forced

to downgrade. There is nothing wrong with our 17.5% GDP health care cost, other than the fact that many patients and our economy cannot afford it.

How much do you want to spend on health care? For some who value health, 17.5% may be acceptable. However, for individuals or families who are struggling to find employment or make payments for dependents, housing, food, transportation, and education, 17.5% GDP may be too high a cost. Can we reduce this cost and provide economy-level rates without sacrificing lives? There is evidence that this is possible. The United Kingdom and Canada provide health care at 9.4% to 11.2% GDP, respectively. Although critics point to the delays that those systems experience, overall health outcomes and mortality rates are similar to US rates. Thus, economy-level models do exist if we can lower our patients' expectations for service.

For those who want more than just economy-level service, they can opt for and pay for additional first-class features, including concierge services. If they pay a higher rate they will expect better service. Although a two-tiered system may not be egalitarian, our society has many systems with multiple service levels within the housing, transportation, and service industries. We are often accustomed to making do with less because only a very small number can afford everything in first class. In health care, we will have to accept reduced access and loss of some costly diagnostic and treatment modalities that provide only marginal benefit.

Are clinicians ready to lower costs? Most physicians feel that lawyers (60%), insurance companies (59%), drug and device manufacturers (56%), hospitals (56%), and patients (52%), but not physicians (33%) bear the responsibility for controlling health care costs. Although physician costs represent only a fraction of total health care costs, physicians interact directly with patients and order most hospital admissions, diagnostic tests, and treatment therapies. Thus, clinicians must participate and play a major role in controlling these costs.

Patients and their families also need to play a role. However, patients and their families are often excluded from cost considerations. Prices are almost never discussed in our consent process. Although detailed pricing is expected for consumer services and retail merchandise, health care prices are often hidden until a patient arrives at the pharmacy or receives the hospital bill in the mail. Without easy access to pricing, patients and their families naturally opt for the pricy deluxe and first-class options.

How can physicians and patients help control health care costs? We need to make cost information a part of the procedure and treatment consent discussion. We need to make comparative hospital and outpatient costs easily available so patients can shop for value. We need to make economy-level care available with significant co-payments and high deductible plans to allow patients to really consider cost when selecting options. We need to help detect and eliminate fraudulent claims and inappropriate use providers. We need to delegate to team members. We also need to delegate some diagnostic and treatment care to our appropriate health team members. Although initial assessments and overall direction can be performed by the team members with the best training, much of what we do can be delegated to our health care associates (physician assistants, nurse practitioners, nurses, technicians). In many cases, this will improve access, lower costs, and reduce readmissions.

Although physicians believe that insurance companies bear some responsibility for controlling costs, most physicians support continuing this system versus single-payer reimbursement. Establishing new insurance exchanges will improve access to insurance and thus health care, but will not lower costs unless there is active price competition. In reality, however, we are gradually sliding to single-payer reimbursement with increased enrollments in Medicare, Medicaid, and indigent care. The PPACA may hasten or delay this slide, but there is no guarantee that a single government payer would automatically drop administration costs or documentation needs.

The budget and debt ceiling have been extended, but for only a short time. Instead of kicking the can down the road again, we need to begin making major changes in health care delivery. There will be no magic solutions. Instead, it will require hard work to delegate care and improve efficiency for all providers while we educate our patients on choosing wisely to achieve adequate but lower-cost health care. ■

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