Physician Stewardship of Health Care in an Era of Finite Resources

David B. Reuben, MD
Christine K. Cassel, MD

ALTHOUGH THERE ARE VARYING OPINIONS ABOUT THE quality of health care in the United States, there is consensus that it costs too much. Even if the Patient Protection and Affordable Care Act saves some money, the proliferation of technology and the aging US population are projected to bankrupt the Medicare Part A Trust fund by 2024.[1] Unless a dramatic and unlikely shift occurs in public opinion toward increasing the percentage of gross domestic product devoted to health care (17.3% in 2009),[2] the amount the United States can spend on health care is finite.

Various approaches for containing health care costs have been proposed, including eliminating waste (eg, duplicative tests; and unnecessary tests, procedures, and treatments that convey no health benefit), which may account for as much as 30% of health care costs[3]; reducing diagnostic and treatment variation among clinicians and between communities[4]; and reforming medical liability to decrease the practice of defensive medicine.[5] Many of these approaches (eg, reducing overuse, avoiding preventable complications, and improving inefficient processes) are under way in both private and public sectors.[6]

Although some have argued that the hundreds of billions of potential savings are enough to make US health care sustainable,[6] eliminating waste and variation is easier said than done and as a sole approach is unlikely to solve the long-run overspending problem.[7] Ultimately, society must decide which health care costs really add value and the relative contributions of different payers.

Health care costs are directly related to decisions made in clinical practice. These decisions are difficult to influence because they are made in the context of individuals who are often sick and vulnerable, with little understanding of the potential benefits and risks of diagnostic and therapeutic options. Patients seek help from physicians and physicians chose careers to provide this help, or at least the hope of it. Because of this relationship, it is futile to expect that changing physicians' behavior through evidence and shared decision making alone will solve the problem of high health care costs. Alternative approaches will be necessary.

Stewardship of finite health care resources can occur at several levels that are not in the context of the care of individual patients. Such an approach gives clinicians a framework for patient care, promotes fairness, minimizes personal biases and emotional influences, and has been advocated as a social contract for contemporary society.[8]

The highest level of stewardship should be at the national and state policy levels, at which strategy about public funding and public health is developed. At this level, there is public accountability through elected officials and their appointees. These decisions should be guided by scientific evidence, including comparative effectiveness research, and open deliberation about values through professional and consumer groups. Although efforts have been made to prioritize health objectives, the funding and implementation of efforts to accomplish these objectives have been politically divisive and fragmented rather than being through a transparent national strategy.

The second level of stewardship is at the payer level, at which insurance coverage decisions are made (eg, exclusions, restricting coverage, increasing co-payments and deductibles) but these are usually not based on a clear analysis of public benefit. Methods currently used throughout health care delivery (eg, lack of coverage for hearing aids, limitations on skilled nursing facility days and home care services, co-payment for prescriptions) generally shift costs onto patients. Findings from comparative effectiveness research should guide better decisions about which services should be covered and how to value services. Based on evidence, payers can set boundaries on reimbursement (eg, only paying for a defined set of essential benefits or paying an amount comparable to an equally effective but lower-cost service). Ineffective, marginally effective, or very expensive treatments could be available for patients who chose to pay for them. This approach makes more sense than high deductibles and co-pays for known effective treatments. At the extreme, payers could identify and exclude physicians who excessively use procedures of little value.

The third level of stewardship is at the practice level. For example, a group practice may review evidence and adopt a policy to not offer specific services that evidence shows are ineffective. Similarly, a medical group may develop a for-

Author Affiliations: Division of Geriatrics, David Geffen School of Medicine at UCLA, Los Angeles, California (Dr Reuben); and American Board of Internal Medicine, Philadelphia, Pennsylvania (Dr Cassel).
Corresponding Author: David B. Reuben, MD, Division of Geriatrics, David Geffen School of Medicine at UCLA, 0945 LeConte Ave, Ste 2339, Los Angeles, CA 90095-1687 (dreuben@mednet.ucla.edu).

mulary favoring generic medications over more expensive brand-name medications with comparable effectiveness.

At the individual clinician level, stewardship is facilitated by evidence-based data to guide decision making. Based on the patient's diagnosis or prognosis, some treatments may be ineffective or minimally effective and, therefore, should not be offered. For example, a patient with severe dementia and metastatic cancer might not be offered the option of chemotherapy that might extend life by several months. In some situations, available evidence may not provide a clear recommended course and decision making may be difficult, especially when it involves cessation of expensive treatments.[9] Here, a clear policy context is helpful to physicians. In a recent policy paper, the American College of Physicians stated, "resource allocation decisions are policy decisions that are most appropriately made at the system level, not at the bedside."[5]

Stewardship also can occur at the patient level. Although it is unreasonable to expect patients to consider societal costs in making personal health care decisions, as citizens they can participate in stewardship by addressing some larger questions about allocation of health care resources. Patients can become informed about the evidence for their own health care options and lead rational community discussions about policy arguments in legislation and elections.

Stewardship at each of these levels will be difficult to implement but as a nation, coherent approaches to these complex issues must be developed. Clinicians may not agree with every limitation on care but once established, can abide by them and can discuss the implications with patients. Failing to set limits promotes arbitrariness and inequities in how much care is provided to patients.

Physicians should support and lead efforts to contain health care costs. By virtue of their positions in society, both as stewards of their patients' health and as professionals who understand health care decisions and their respective consequences, physicians are uniquely qualified to move the discussions forward. As trusted professionals, the very qualities that make it so difficult for physicians to make these decisions in individual cases also make physicians well suited to lead the conversations about the policy frameworks. Indeed, there have been some notable examples of professional organizations identifying 5 tests that should never be ordered, physician-determined formularies, and physicians working with consumers and government to prioritize covered benefits (eg, the Oregon Health Plan).[10] Recently, the American College of Physicians took an important leadership step by articulating principles for resource allocation.[5] But more will be needed, including physician guidance in identifying what not to do and what could be done but facilitated at the expense of the individual patient rather than by insurance coverage.

As medicine progresses and the ability to provide improved treatment increases,[7] the costs of health care will inevitably continue to rise. Despite the best efforts to improve efficiency, the effectiveness of that strategy will be overwhelmed by the availability of clinical services and the pressure to provide them. Stewardship at multiple levels will be needed to provide high-quality, equitable care for all US residents and the ability to live within the nation's means.

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