PATIENT SAFETY BLOG

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An Honest Discussion of "Appropriate" Care

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At a time when the cost of health care represents nearly one-fifth of the U.S. gross domestic product, it is reasonable and necessary to discuss the notion of “appropriate care.” But a fair and conscientious examination of what measures, personnel and technologies should be employed to diagnose and treat medical problems must get past such inflammatory terms as “death panel,” “rationed care” and “tort reform” (that is, malpractice lawsuits). That kind of language does not advance or inform the discussion.

A recent commentary in the New England Journal of Medicine grappled with the topic, and the breadth of comments by its readers indicated how all of us – providers and consumers – must drive meaningful health-care reform.

Victor R. Fuchs, Ph.D., is an economist affiliated with Stanford University and an expert on health policy. His commentary, “The Doctor’s Dilemma – What Is ‘Appropriate’ Care?”, discusses the difference between what is “ethical” and what is “appropriate.”

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“How can a commitment to cost-effective care be reconciled with a fundamental principle of primacy of patient welfare?” he asks.

We are a nation that celebrates the individual and enables development of expensive drugs, devices and procedures. Our default position is that if something is new! and improved! it should be widely used. But, Fuchs notes, “[T]echnologies that may provide high value for carefully selected patients are often used indiscriminately for a much larger cohort of patients.”

Nine in 10 medical bills are paid by health insurance (public or private), not by the patient. That distances individuals from the reality that even the newest (and often hideously expensive) procedure or gizmo isn’t always the best prescription. For example, U.S. patients average almost three times as many magnetic resonance imaging scans as Canadians. But there are no significant differences in our respective health outcomes.

Fuchs argues that if we didn’t have widespread insurance coverage, fewer physicians would order expensive procedures unless the chance of substantial benefit was demonstrable; that is, unless it was cost-effective. U.S.-style insurance is cost-insensitive, and that can undermine “appropriate.”

The insured patient, he says, usually wants any and all care that might possibly help, regardless of cost. And although the physician might know that it’s probably not going to help in certain cases, that it isn’t cost-effective, might recommend it anyway because he or she:

- wants to keep the goodwill of the patient;
- believes he or she is protecting against a malpractice claim;
- assumes that denial is “inappropriate” and “unethical.”

No one here – not patient, not provider – is ill-intentioned or looking for anything other than a solution to a medical problem. We aren’t the problem, Fuchs says, our system is.

The solution isn’t forcing patients to put “more skin in the game” – that is, subsidizing more costs of their care. The need for an annual cap on patients’ payments, above which insurance pays, is widely

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accepted. But today, 5 out of 100 patients account for 50% of annual health-care costs. That means the most expensive procedures go to patients whose costs have exceeded the cap.

Nor is the answer eliminating so-called “unnecessary” care, which is desirable, but which Fuchs says accounts for smaller potential savings than is usually claimed. If some procedures turn out to be useless or even harmful for some patients, that’s because the diverse nature of patient populations make it difficult or impossible to determine in advance who will benefit by a procedure and who won’t.

If a physician is paid on a fee-for-service basis and the patient has open-ended insurance, the default is more likely to fall to the “possible” than the “cost-effective” side of care. If so, the benefit other patients might get from the resources saved with cost-effective medicine isn’t necessarily clear.

Physicians who are paid on an annual fee-per-enrollee basis in a defined population are more likely to practice cost-effective medicine. The resources saved in those practices are used for the benefit of the defined population, which includes the physician’s patient.

Per capita health-care spending in Canada is nearly half what it in the U.S. Canadians have universal care, a defined budget and a default for the prudent expenditure of resources.

“In short,” Fuchs summarizes, “when physicians are collectively caring for a defined population within a fixed annual budget, it is easier for the individual physician to resolve the dilemma in favor of cost-effective medicine. That becomes ‘appropriate’ care. And it is an ethical choice … because if all physicians act the same way, all patients benefit.”

But we don’t have a Canadian-style health-care system, and as one physician pointed out in the online comments to Fuchs’ article, for people who are uninsured, there is no context for “appropriate.”

Another physician commented that by cultivating superior clinical skills, remaining current on medical developments and establishing honest rapport with patients, physicians can bypass the scorched-earth approach to treatment, resulting in lower costs.

A particularly articulate physician said, “Americans have come to expect unlimited health care resources while assuming little to no individual responsibility for paying for it. … The differences

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between American health care and other systems have been identified for years by Dr. Fuchs and others…. There is no system, not the market, not single payer, that can bridge the gap between this expectation and a diminishing ability of society to meet it. The hope for political compromise and develop a rational means to modifying our system so as to maximize benefit and minimize harm is unlikely until we come to accept this fact as a people."

Ouch. But, he's right – you can't treat the festering sore until you yank off the bandage and examine, without political agenda, the problems that created it.

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