Editorial

Cutting the Cost of Health Care:

The Physician's Role

Our country is remarkably generative in the development of new diagnostic tests, drugs, and procedures—and remarkably undisciplined in their deployment.[1]

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The ever-increasing cost of health care is reason for every American to be concerned. In 2008, for example, healthcare expenditures in the United States reached $2.4 trillion,[2] accounting for 16% of gross domestic product.[3] By 2013, these expenditures had risen to almost $3 trillion annually, 17.4% of gross domestic product.[4] Worse still is the amount of wasteful spending in health care. A study by PricewaterhouseCoopers' Health Research Institute, published in 2010, calculated wasteful spending at up to $1.2 trillion, more than half of all spending on health.[5] In 2012, Berwick and Hackbarth presented data that placed the lowest estimate of wasteful spending at 20% of all healthcare expenditures; however, they emphasized that the actual total might be far greater.[6]

During the past 40 years, various steps have been taken to control healthcare costs, including global budgeting, managed competition, cost-sharing, and pay for performance.[7] Unfortunately, no effort of any sort has proved effective.

There are many different causes of these exorbitant expenditures. Among them are an aging population; personal health habits such as smoking and improper diets that can lead to cancer, cardiovascular disease, and diabetes mellitus; the continuous development and use of expensive new drugs and procedures; and a reimbursement system that often rewards both inappropriate and appropriate uses of technology.[8] I will mention other important causes in this editorial, but my main focus will be on the role that physicians play in creating this costly mess and on how we can help to fix it.

The Practitioner's Responsibility

It is sometimes said that the most expensive technology in today's health care is the physician's pen. In that regard, I agree with policymakers who contend that more than 80% of our overall healthcare costs result from the patient-care decisions that we physicians make.[8] We are the ones who order the expensive new drugs,[9-11] tests, and procedures, often unnecessarily or inappropriately, and at times indiscriminately. Take, for example, the activity in almost any hospital in the U.S. There you will find—more often than not—that the daily number of computed tomographic scans and magnetic resonance images exceeds the daily number of simpler, cheaper, and usually sufficient studies, such as plain films of the chest or abdomen. You will also find that these expensive tests are typically performed in the absence of convincing written justification, a properly recorded and sufficiently detailed medical history, and an adequately conducted physical examination. To make matters worse, up to half of high-tech imaging procedures fail to provide information that improves patient welfare.[12] Furthermore, except for magnetic resonance, these procedures deliver high and potentially dangerous doses of radiation, all too often unnecessarily. Facts such as these—high costs and low quality—prompt emphasis on high-value care (HVC), defined as care that balances potential benefits against the potential harms and costs of tests and treatments.[13]

What drives physicians to overuse these exorbitant tests and procedures? From my vantage point as a medical educator, the most prevalent reason is "fishing"—scanning

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the body part that is thought to be the source of the patient's symptoms or problem, hoping that a diagnosis will somehow be reeled in.[14] This routine takes little of the physician's time, requires no special expertise, demands no discriminative thought, and serves as an easy and convenient way to obtain a lot of information quickly. In addition, it becomes a necessity for many of our current trainees and recent graduates who are laboratory oriented, deficient in clinical skills, and poorly informed on the natural history of diseases.[15]

Other typical reasons for overreliance on advanced technology include the fear of litigation (which results in the practice of "defensive medicine"[16,17]), the discomfort associated with diagnostic uncertainty or with possibly inadequate follow-up evaluations, a perceived need to satisfy patients' demands, and insufficient knowledge of the tradeoff between the benefits, harms, and costs of most tests and procedures.[18]

One additional point deserves emphasis. Imaging costs are reimbursed on a per-procedure basis. Consequently, performing more procedures yields more revenue for the institution and for the physician who performs the procedures. Moreover, reimbursement for imaging studies is high in comparison with that for many other healthcare services. This disparity can encourage non-radiologists to acquire ownership interest in imaging equipment from which they can benefit financially.[12]

How do U.S. physicians in general view the problem of high healthcare costs? In a cross-sectional survey mailed in 2012 to 3,897 U.S. physicians randomly selected from the American Medical Association's Masterfile, 2,556 responded (a 66% response rate).[19] Only a third of the respondents believed that practicing physicians have a major responsibility to reduce healthcare costs. In contrast, most respondents implicated trial lawyers, health insurance companies, hospitals and health systems, pharmaceutical and device manufacturers, and patients as the parties chiefly responsible.

In that same survey, 76% of the physicians claimed to be aware of the costs of the tests and treatments that they recommend. However, evidence from several studies contradicts those assertions. A systematic review of physicians' knowledge of diagnostic and nondrug therapeutic costs included 14 studies. The authors of the review found that just a third of physicians' estimates were within 20% to 25% of the true costs.[20] Because only 3 of the studies were from 2000 and later, it is possible that the findings do not reflect physicians' current awareness of diagnostic and therapeutic factors. Regardless, the studies covered a 30-year span, during which the awareness did not change substantially. The authors therefore concluded that physicians' awareness of the tested items remains poor.

As part of another study,[21] internal medicine residents and faculty at an academic tertiary-care hospital rated their agreement with a series of statements about healthcare charges, and they estimated the charges for 15 frequently ordered diagnostic tests. Estimates within 25% of the true charge were considered to be correct. Seventy of the 126 eligible participants (56%) returned their surveys. Less than a quarter of all responses were correct.

The Educator's Responsibility

There is strong evidence that the education of today's medical trainees falls short in regard to cost-consciousness and HVC. The results of a recent nationwide survey of more than 18,000 internal medicine residents disclosed that only one quarter of them had a working knowledge of the costs of the tests and procedures that they ordered.[18] However, most of them did report at least some exposure to faculty who taught high-value care. Comparable findings came from a much smaller study of surgical trainees.[22] Another investigation showed that physicians with less than 10 years of experience have higher cost profiles than do physicians with 40 or more years of experience.[23] The authors of that study suggested that the more costly practice style of newly trained physicians might be (and I believe is) a driver of rising healthcare costs overall.

Results of a survey of U.S. internal medicine residency training programs provided ample explanation for such inadequate cost-consciousness among internal medicine trainees.[24] Of the 370 programs contacted, 261 (70.5%) completed the cost-conscious care questionnaires. Only 14.9% of the responding institutions had a formal curriculum in cost-conscious care. Accordingly, it's no wonder that most residents in one internal medicine training program indicated that their supervising physician did not consistently encourage them to consider costs when making their decisions.[25]

Ever since expensive tests and procedures emerged in the 1970s, I have focused keenly on how they are used in patient care. Regrettably, I find that cost-conscious HVC receives little or no attention during teaching rounds. On the bright side, the importance of this subject has caught the nation's attention, and steps are under way to transform graduate medical education to improve high-value care.[26,27] In that light, the Medicare Payment and Advisory Commission recommended that nearly $3.5 billion for graduate medical education be reallocated to programs with curricula that train residents to practice cost-conscious HVC.[26]

Meeting the Challenge

From information presented here and from my own observations locally and nationally, relatively few physicians in the U.S. practice cost-conscious HVC. Increasing their ranks is not only our charge; it is our obligation. Happily, we have the ability to meet that challenge. Each of us should therefore begin by acknowledging that we physicians play a major role in the

genesis of today's healthcare expenditures. Next, all of us should strive to learn the prices of the various tests, procedures, and treatments that we initiate. Finally, and perhaps most important, we must be circumspect in our patient-care decisions. If we collectively adhere to this strategy, our patients will benefit greatly, our trainees will have the proper model to emulate, we will preserve and promote the fundamental principles of our profession, and we will cut healthcare costs substantially.

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