Serving Two Masters – What Practicing Cost-Conscious Medicine Means for Patient Care and the Public Trust

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Outline

1. How the NEJM teed up the questions for today in 1984
2. Managed care 1.0 (1990s) & the managed care backlash
3. AMA ethics policies on practicing cost-conscious medicine
4. Massachusetts as a hotbed of challenge & opportunity
5. Tentative lessons from practice about today's topic

Norman Levinsky: "The Doctor's Master" (NEJM 1984)

"…physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations. **In caring for an individual patient, the doctor must act solely as that patient's advocate, against the apparent interests of society as a whole**, if necessary…When practicing medicine, doctors cannot serve two masters…The doctor's master must be the patient."

Lester Thurow: "Learning to Say 'No'" (NEJM 1984)

"…Instead of stopping treatments when all benefits cease to exist, physicians must stop treatments when marginal benefits are equal to marginal costs **…It will be far better if American doctors begin to build up a social ethic and behavioral practices that help them decide when medicine is bad medicine – not simply because it hurts the patient – but also because the costs are not justified by the marginal benefits**."

In 1984 Thurow Predicted 1990s Managed Care

"…If such norms are developed and then legally defended against malpractice suits, it just may be possible to build up a system of doctor-imposed cost controls that will be much more flexible than any system of cost controls imposed by third-party payers could be. **But if the medical profession fails to do this, sooner or later the United States will move to a system of third-party controls**." *(This is exactly what happened!)*

Why managed care 1.0 crashed and burned

1. Cost-containment policies were set at a distance by insurers
2. These policies were often treated as "proprietary"
3. Policies were often enforced via 800#s ("1-800-just-say-no")
4. Doctors & patients doubted that savings were being put to good purpose
5. Public leaders did not endorse the third-party role
6. Even if policies were excellent the process guaranteed failure

Since 1981, the AMA *Code of Ethics* has told us to be cost-conscious in our practice of medicine

"…While physicians should be conscious of costs and not provide or prescribe unnecessary medical services, concern for the quality of care the patient receives should be the physician's first consideration. **This does not preclude the physician, individually or through medical or other organizations, from participating in policy-making with respect to social and economic issues affecting health care."** (Opinion 2.09; I, VII)

(Issued March 1981; Updated June 1994 & June 1998; Updated December 2003.)

In 2012, the AMA *Code of Ethics* strengthened its endorsement of cost-conscious practice

….Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. **This obligation <u>requires</u> physicians to be prudent stewards of the shared societal resources with which they are entrusted**. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

(CEJA Report 1-A-12: Physician Stewardship of Health Care Resources)

Four requirements for setting cost-conscious policies fairly: "Accountability for Reasonableness"*

- Limits should be based on **relevant reasons** (clinical evidence, individual needs **AND** population needs)
- Limit setting policies & rationales should be **public** (no one will or should trust a black box)
- Limits (policies & decisions) should be **revisable** (new evidence, special patient needs, changed external circumstances – this is a QI orientation)
- The above three conditions – relevance, publicity and revisability – should be **enforceable**.

* Daniels N, Sabin JE. Setting Limits Fairly: Can We Learn to Share Medical Resources? New York: Oxford University Press, 2002 & 2008.

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Components of a fair process for setting cost-conscious policies: #1, the relevance condition

- The needs of individual patients should always be acknowledged – even if they will not be met
- Evidence about effectiveness, comparison to alternatives, and cost should be considered
- And, population needs and opportunity costs should be identified
- All in the context of the resources that are available

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Components of a fair process for setting c0st-conscious policies: #2, the publicity condition

- Understanding & trust are crucial for cooperation in the health care system
- Unless rationales are public, stakeholders may impute bad reasons – cost alone, prejudice, etc
- Over time, transparency fosters public learning
- Publicity allows something like "case law" to emerge – considering previous decisions and rationales in making current decisions

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Components of a fair process for setting cost-conscious policies: #3, the revisability condition

- No policy is perfect – there must be opportunity to criticize and appeal
- New evidence about effectiveness and cost may become available
- Individual differences may create good reasons why exceptions should be made
- We may have misunderstood public values

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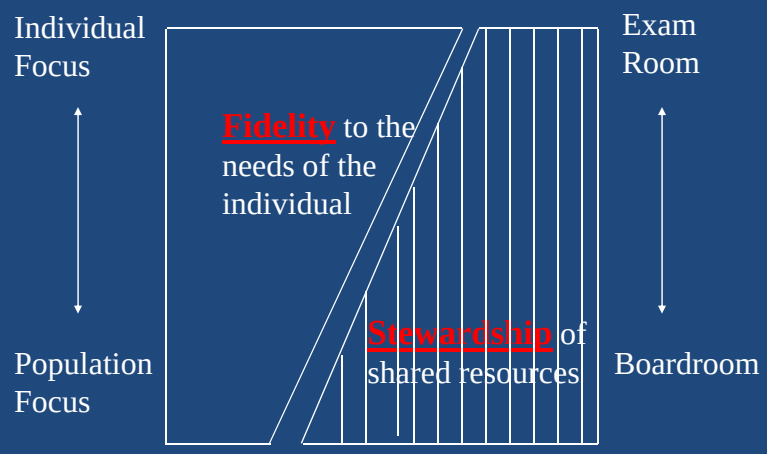
The Values Framework we need to develop in Massachusetts to foster cost-conscious medicine



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Describing fair process is easy - learning to apply and accept cost-conscious practice is the hard part!

- Cost-conscious practice is ultimately about sharing
- How we learn to share as children provides guidance:
  - A cognitive component (the rationale/fairness)
  - An emotional component (tolerating feelings)
- Learning to apply and accept cost-conscious practice will require the same combination of cognitive and emotional elements
- Public leadership is crucial role for this learning process
- Learning to apply & accept cost-conscious practice will take time

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To understand cost-conscious practice & to accept it as fair, we in Massachusetts must (1) understand the denominator (state population) as well as the numerator (individual patient)

$$\frac{\text{My needs \& desires}}{\text{The Massachusetts population's needs \& desires}}$$

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To understand cost-conscious practice & to accept it as fair, we in Massachusetts must (2) understand the denominator and the numerator re opportunity costs – as important as it is, health care is not the only public good

$$\frac{\text{Resources allocated to health care}}{\text{All potential allocations within the Gross State Product (GSP)}}$$

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Through Chapter 224, we the people of MA, via the legislature, have set an expenditure target & asked physicians to practice cost-conscious medicine

A recurrent dialogue with patients about cost: Harvard Community Health Plan HMO (1990s)

JES: I believe we can handle the situation well without using the hospital. Here's what I suggest…

Pt/Family: Dr. Sabin, you're just thinking about cost…!

JES: I agree with you except for the word "just." We members of the HCHP practice should want our doctors and nurses to pay attention to costs. That's how we can offer services like XYZ…

Helping physicians apply & patients accept cost-conscious medicine in Massachusetts – conclusions

1. Dealing with health care limits confronts us with the ultimate limits – disease, disability, & death.

2. Our first impulse as a society has been to avoid the topic altogether.

3. Committing ourselves to cost-conscious practice requires MDs, patients & the public to acknowledge the need for **sharing** resources with others.

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Helping physicians apply & patients accept cost-conscious medicine in Massachusetts – conclusions

4. By identifying the denominator (the state population we are part of) & specifying the cost target, Massachusetts makes it easier to recognize the ethical imperative for cost-conscious medicine.

5. There is no reason to assume that Americans are congenitally unable to understand limits – our "system" has made it easier for us to evade facing the facts.

Helping physicians apply & patients accept cost-conscious medicine in Massachusetts – conclusions

6. The impediment to applying & accepting cost-conscious medicine is more emotional than intellectual - the heart more than the mind.

7. Implementing cost-conscious medicine will take time and will not be easy!

8. In moral terms an individual life may be "priceless," but in terms of meeting the overall needs of a population within limited resources, it isn't.

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Helping physicians apply & patients accept cost-conscious medicine in Massachusetts – conclusions

9. Cost-conscious practice will be more trusted if it is developed via deliberation within specialty groups, group practices, and the house of medicine, as in this forum.

10. We should involve patients and the public in our deliberations and policy-setting.

11. Physicians, patients & the public will only trust cost-conscious practice if they believe quality of care is being preserved and savings are being used for a good purpose.

Helping physicians apply & patients accept cost-conscious medicine in Massachusetts – conclusions

12. Cost-conscious practice should start with reducing "waste" as proposed in the "Choosing Wisely" campaign. By mid 2013, 31 specialty societies will be participating! (http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx)

13. True "rationing" should only be considered if & when reducing "waste" doesn't do the job.

14. We physicians will either be leaders or spoilers of the Massachusetts effort. The choice is ours.