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EDITOR'S PAGE

# Controlling Waste: What's in it for Us?

We, the citizens of the United States, spend an increasingly disproportionate amount on health care. By whatever measure, whether it is the total expenditure as a percent of the gross domestic product (GDP), the annual rise in health care costs, the per capita expenditure on health care, or the consumer price index as compared to the cost of medical care, the United States spends more on health care than any other nation. Estimates are that the U.S. expenditure on health care may grow to 20% of the GDP by 2015 (1). The consequences of rising health care costs are immense. They include a reduction in the resources available for other worthwhile projects, an erosion of wages, the undermining of the competitiveness of U.S. industry in the global market, and the imposition of crushing indebtedness on this generation and an even greater impact on the generations to follow. Moreover the burden of this cost is going to be born by an increasingly smaller component of our aging population. The polarizing political discourse on health care reform is likely to consume much of our government's time and much of the public's attention; but we, engaged in health care, must acknowledge the unsustainable cost of American medicine and become active participants in finding solutions. What can we do?

Among the principle drivers of our continually expanding health care expenditure are two that are difficult to contain, namely, technological advances and the aging of our population. While we can provide no immediate solution to these particular drivers, the enormity of cost associated with them demand that we, as physicians, help to lead and focus the discussion in these areas. Certainly we and our patients are excited about the promise of new technology. Moreover, when making medical decisions, we interventional cardiologists have a natural pro-technology bias. The cost effectiveness of some new technologies, however, may be brought into question as their costs continue to sky rocket. Similarly, the demographic shift to an older population presents major challenges. These more fragile patients typically incur the highest costs. By 2030, 19% of Americans will be 65 years of age or older. An additional driver of health cost is the fee-for-service payment policy (more service = more fees). The fee structure favoring technology over cognitive endeavors has been eroded somewhat in recent years but continues to be an incentive for high-tech endeavors. As a nation we need to begin to wrestle with the issue of how to provide quality care to elderly persons without impoverishing them and their families. But as physicians, what is in it for us?

An area of cost overrun that we should become activists in is management of medical waste. Although physician income is not the major driver of health care costs, physician's decisions do account for almost 80% of all health care expenditures (1,2). Medical waste, as defined as health care spending that can be eliminated without decreasing the quality of care, has been estimated by the Institute of Medicine to be 30% (2). The components of medical waste are listed as: failure of care coordination, administrative complexity, failure of execution of care processes and fraud, and overuse of medical resources, which cannot be overemphasized. We must take on the challenge of overuse of medical resources. Unfortunately, even when evidence is lacking, the present incentives are often in the direction of recommending costly invasive therapies over more conservative options. There is usually little or no financial incentive to properly counsel the patient as to the appropriateness of considering less costly approaches. The pro-intervention bias may also be reinforced by referral pathways, as the specialists may assume that the referral is a request for aggressive intervention. The natural incentive for device manufacturers is to market enthusiastically and direct-to-consumer marketing brings

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pressure from the patient and the family which may be based on misguided assumptions about what represents appropriate therapy (3,4). The current fee-for-service system provides added incentives to select a more invasive and costly approach. Physicians interested in controlling waste often find themselves swimming upstream. Nonetheless we are not alone. As we take on this challenge we should realize that many of our professional organizations are also addressing the issue. To help reduce waste in the U.S. health care system and promote physician–patient conversations about making wise choices about treatments, 9 medical specialty societies have joined the American Board of Internal Medicine Foundation and Consumer Reports in the first phase of the Choosing Wisely campaign, including the following: American Academy of Allergy, Asthma & Immunology; American Academy of Family Physicians; American College of Cardiology; American College of Physicians; American College of Radiology; American Gastroenterological Association; American Society of Clinical Oncology; American Society of Nephrology; and the American Society of Nuclear Cardiology. As part of Choosing Wisely, each society has developed a list of 5 tests, treatments, or services that are commonly used in that specialty and for which the use should be re-evaluated by patients and clinicians (2,5).

In order to encourage engagement in waste avoidance, the physicians of Emory Healthcare have been offered the following steps:

1. Promote the concept that physicians should commit to forge a true partnership with each patient built upon forthrightness, transparency, and patient engagement.
2. Each physician should become familiar with any Top 5 Lists that their professional society has published, and be certain that allied health professionals are also familiar with the lists.
3. The physicians in each specialty should agree on 2 other procedures to add to the list.
4. Each of the recommendations should be supported by clinical guidelines and evidence that could be retrieved from the electronic medical record and given to the patient.
5. Identify one duplicate process that can be eliminated.
6. Incentivize staff to uncover one waste-saving step (regardless of how small).

Careful scrutiny of the literature by the public will reveal that most of the difference in the cost of health care in this country, as compared to other countries is driven by physician decisions. If we begin to address the issue of waste before new payment models are mandated, we can demonstrate that we are committed to reducing health care costs as a means of serving the patients and their family, rather than being self-serving. Furthermore, if our initial efforts focus upon the most egregious causes of waste and occur without a government mandate to do so, we can demonstrate to a skeptical public that we are genuinely protecting patients' welfare and not simply rationing care. If we convince that skeptical public, we will have gone a long way in enhancing our profession. That's what's in it for us.

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## REFERENCES

1. Berwick DM, Hackbarth A. Eliminating waste in U.S. health care JAMA 2012;307:1513–6.
2. Cassel CK, Guest JA. Choosing Wisely: helping physicians and patients make smart decisions about their care. JAMA 2012;307:1801–2.
3. Grady D. Reasons for overtreatment. Arch Intern Med 2011;171:1586.
4. Brett AS, McCullough LB. Addressing requests by patients for beneficial interventions. JAMA 2012;307:149–50.
5. Wolfson DB. Are the top 5 recommendations enough to improve clinical practice? Arch Intern Med 2012;172:1020–2.