Journal of the American College of Cardiology
Vol. 51, No. 16, 2008

Published by Elsevier Inc.
ISSN 0735-1097/08/$34.00
doi:10.1016/j.jacc.2008.04.001

President's Page: Quality Begins First With Personal Responsibility

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ACC President

It seems pretty certain, unless trumped by a recession, that this next election will set the context for some form of increased insurance coverage. There are 47 million uninsured people in our country; 40% of them are young, and a significant proportion of them represent the 10 million immigrants who have entered our country in the last five years.

Interestingly, about 10 million of the uninsured have incomes greater than $75,000. Most could probably afford insurance but choose not to buy it. Another 15 million are eligible for insurance, but fail to sign up—leaving about 24 million, some citizens and some not, who cannot afford insurance. The emergency departments and you and I deliver free care to all of these people. Is there any other service provider in this country that provides as much uncompensated support?

Talk about universal coverage does not necessarily mean single payer coverage. In every country with the exception of Canada where it is illegal, experiments with multiple insurers versus a single insurer are ongoing. Competition clearly seems to have the advantage, although the massive amount of paperwork, administration, and cost inherent in our insurance system is deplorable and certainly provides no benefit to you, to me, or to our patients. It leaves many of us frustrated and angry, and it has taken some of the joy and enthusiasm out of practice.

Escalating Costs Versus Lower Value

We may have no control over what form insurance will take, but we do have the ability to control and influence the cost of health care. Health care in this country is projected to cost $2.7 trillion in 2010, nearly 30% more than in 2004—an amount that equals twice as much as all of Europe combined. Family insurance premiums are projected to double from $6,200 in 2004 to $12,100 in 2010, just $100 less than an entire year's salary for a lower tier government worker. The U.S. spends about $500 billion more per year than other industrialized countries after adjusting for size, population mix, and levels of disease. Economic projections suggest that health care spending will grow about 6.5% per year. If true, federal outlays for health care could reach 40% of all federal spending by 2015.

So what do we get for this huge amount of spending? Fewer physicians per capita, fewer hospital beds, fewer surgical procedures, and fewer physician visits. Twenty years ago we ranked #11 for life expectancy, and now we rank #42—worse than Jordan or the Cayman Islands. We are ranked #19 in reducing preventable deaths—a 4% improvement since 1997, while the average improvement for other Western countries was 17%.

Is there any good news? Yes, we do have one of the shorter waiting times for elective surgical procedures, but even in that, they are not lower than Germany. A recent study also ranked the U.S. last on 4 of the 6 measures derived from the Institute of Medicine framework for quality.

Some of us may say dollars spent on health care are okay because we are an industry that employs a lot of people and patients will be better off for it. Economists and business leaders argue that the costs are excessive and the dollars spent are disproportionate

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to the value offered to patients. They point to ways in which excessive health care costs hurt some of the other economic drivers in our country.

We have to be concerned that the continued increased cost of health care will soon result in health care becoming unaffordable for the lower middle class of our country, for retirees, and for others.

Where's the Value?

As health care professionals, we have a serious value proposition problem. The Integrating the Healthcare Enterprise estimates that 30% of health care is of little value either because it is ineffective or is inefficiently delivered. Others have shown large differences in end of life care across geographic regions; for example, the cost of end of life care in Southern California is 4 times higher than for northern California. In his many studies, Jack Wennberg, the Dartmouth physician health economist, has shown large geographic variability in the use of cardiovascular diagnostic testing and procedures, and despite careful analysis, he has never found a difference in patient outcomes or satisfaction with their care. There are Medicare regions in my own state of Michigan where the use of nuclear stress testing is 4 times that of Rochester, Minnesota. How can we explain this?

I believe the time has come when we all must realize and accept that despite all of the innovation and marvelous progress in American medicine, the status quo is unsustainable.

Holding Ourselves Accountable

So, that said, what can and should we do as health care professionals? First, we should become more accountable for the dollars spent. In our profession, we can order expensive procedures with a few strokes of the pen and have no obligation for the dollars spent.

A fellow pilot came to me awhile back. Healthy all of his life, he had a stress perfusion scan for some atypical symptoms. He dropped his ST segments 3 mm; in other words, his exercise electrocardiogram became very abnormal. The scan was also markedly abnormal. Next he was sent for a calcium score and cardiac computed tomography; the following week he was sent for a pharmacologic echocardiography. He was concerned and asked me what this meant and what he should do. I told him to get a new doctor. What had been done in his case was intolerable.

We must create greater value for our patients. At the American College of Cardiology (ACC), this concept is at the core of the Quality First Campaign. Enhancing value will not be easy. In the past few years we have been working harder, seeing more patients, and providing newer testing and treatment options—possibly, in part, to maintain our incomes. This just simply cannot continue. We can't afford it, our children can't afford it, and in fact, most people don't want it. Most really want only what is best for them. Health care reform needs to be about the quality of care we deliver—not the amount.

For some, focus on value, not volume, could mean loss of income, but we need to remember that we chose to become part of a profession in the service of people. We are not peddlers of valueless goods, and we all believe in being accountable to our patients. It is time to be accountable.

Some of us have other objections to change. However, the arguments that we first must have total tort reform to protect us from malpractice or that we first need additional studies of the newest test or procedure because last year's are not relevant don't resonate with our patients, the payers, or the Congress.

We can lead health care reform by putting our energies into improving quality. If we get out in front, it will be a very powerful way for us to also shape payment reform—that is, getting us paid well for doing the right things and not simply for the number of things. Jack Lewin, MD, the Chief Executive Officer of the ACC, has often said that if you are not at the table in shaping health care reform, then you will likely be on the menu.

Our two fundamental opportunities are to improve patient safety and to increase the value of care provided. We must consistently choose what works best at the lowest cost and apply it until we have found something of better value and more cost effective to replace it. This will be difficult for many of us because we don't think that way—we have been taught to be independent, to be in that upper left personality quadrant—but will it really be so difficult?

I offer an analogy from aviation. Pilots are smart people and strong decision makers who must constantly deal with the unexpected during a flight, but when it comes to flying a certain model of airplane, each uses the same sequence of steps and does each task the same way for that particular aircraft. This was not true some 20 years ago when airlines and pilots determined their own procedures in flying a plane. Aviation experts questioned that approach and found then what we are finding now—the independent approach devoid of standards or criteria was neither safe nor efficient.

Medicine is not that different. It will still be intellectual and test our abilities to the maximum even if we adhere to what has been shown to be the best and least costly initial approach for the patient.

How do we make cardiovascular medicine safer and more efficient? We follow the guidelines, implement appropriateness criteria, and get feedback on our performance. At present, many of us may be inconsistent at applying the criteria and guidelines because the information resides in a journal on a shelf. However, the lack of an effective information technology infrastructure should not prevent us from doing as much as possible with what we have and what we can control, and we need to pursue an information technology infrastructure.

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We also need to take advantage of what is available. The ACC has spent millions in the past decade on registries for catheterization labs, for defibrillator implantation, for patients with acute coronary syndromes, and now for patients in the outpatient setting. If you have not done so, I urge you to join your peers and implement these registries, including the new IC3 outpatient registry.

As your president, I pledge to work to ensure that the ACC campaigns aggressively for quality health system reform. Your advocacy dollars will be spent to convince our congressional leaders that we need fair payment when we provide quality care—payment that offsets income reductions for doing fewer and more cost effective procedures.

At the end of the day, though, we must determine a vision for change—a vision of health care professionals who act not out of self interest but in the interest of their patients—and we must communicate and persuade others to follow us. As our Henry Ford Chief Executive Officer says, patients come first. To lower costs and provide more value, we must make health care more convenient, rely on more self care, and use only effective technology. Ironically, putting patients first is the only way to increase our respect and practice viability.

Note: This column is excerpted from Dr. Weaver's Convocation speech, March 31, 2008, Chicago, Illinois.

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