Choosing wisely: What's going on?

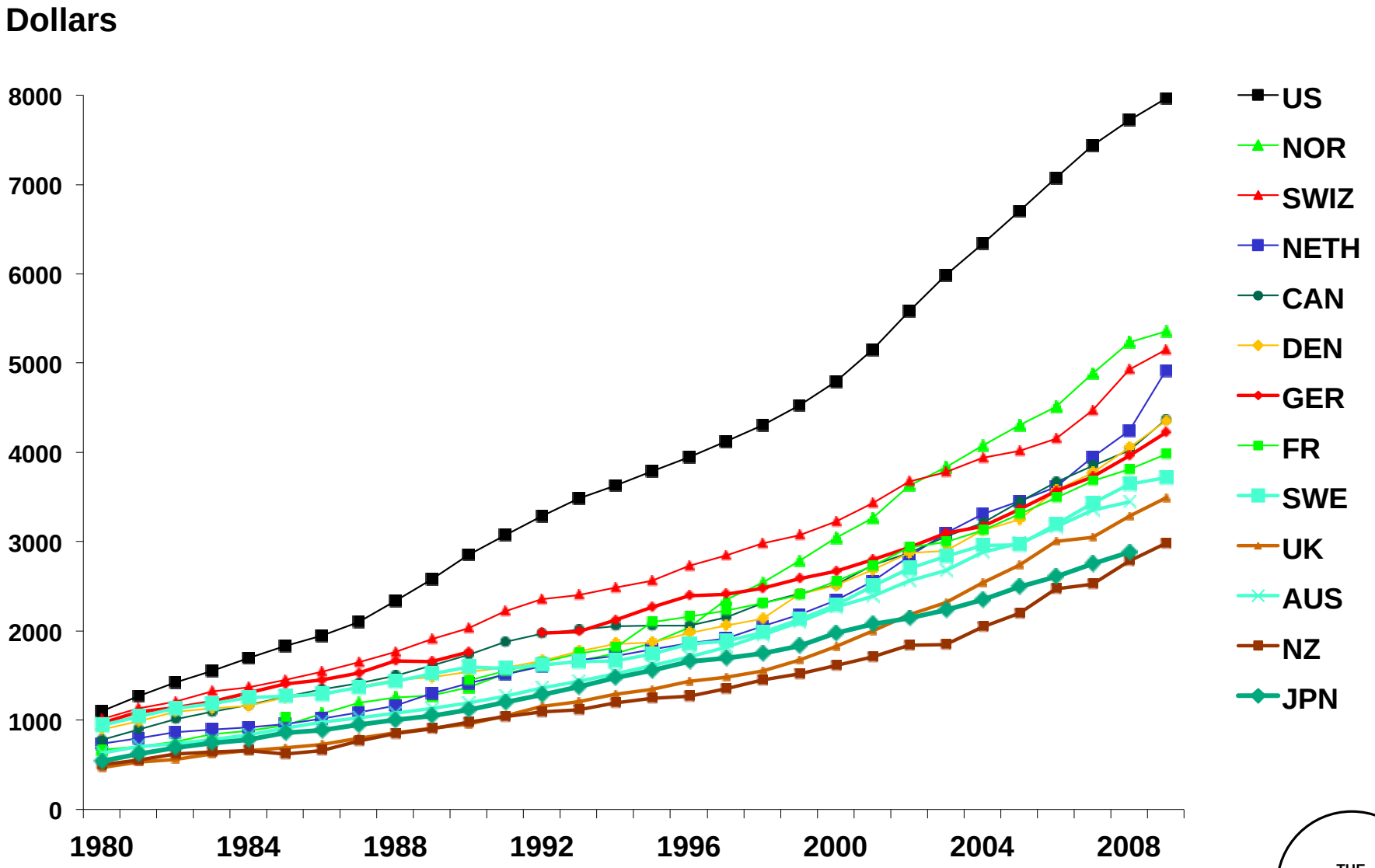
Prof. H. Erdal AKALIN, FACP, FIDSA

Turkish Society of Internal Medicine, Past President

- Around the world, rising health care costs are claiming a larger share of national budgets.
- The rapidly increasing cost of health care, driven by new technologies and treatments, and increasing utilization are a challenge that virtually all industrialized societies are struggling to combat.

Average Health Care Spending per Capita, 1980–2009

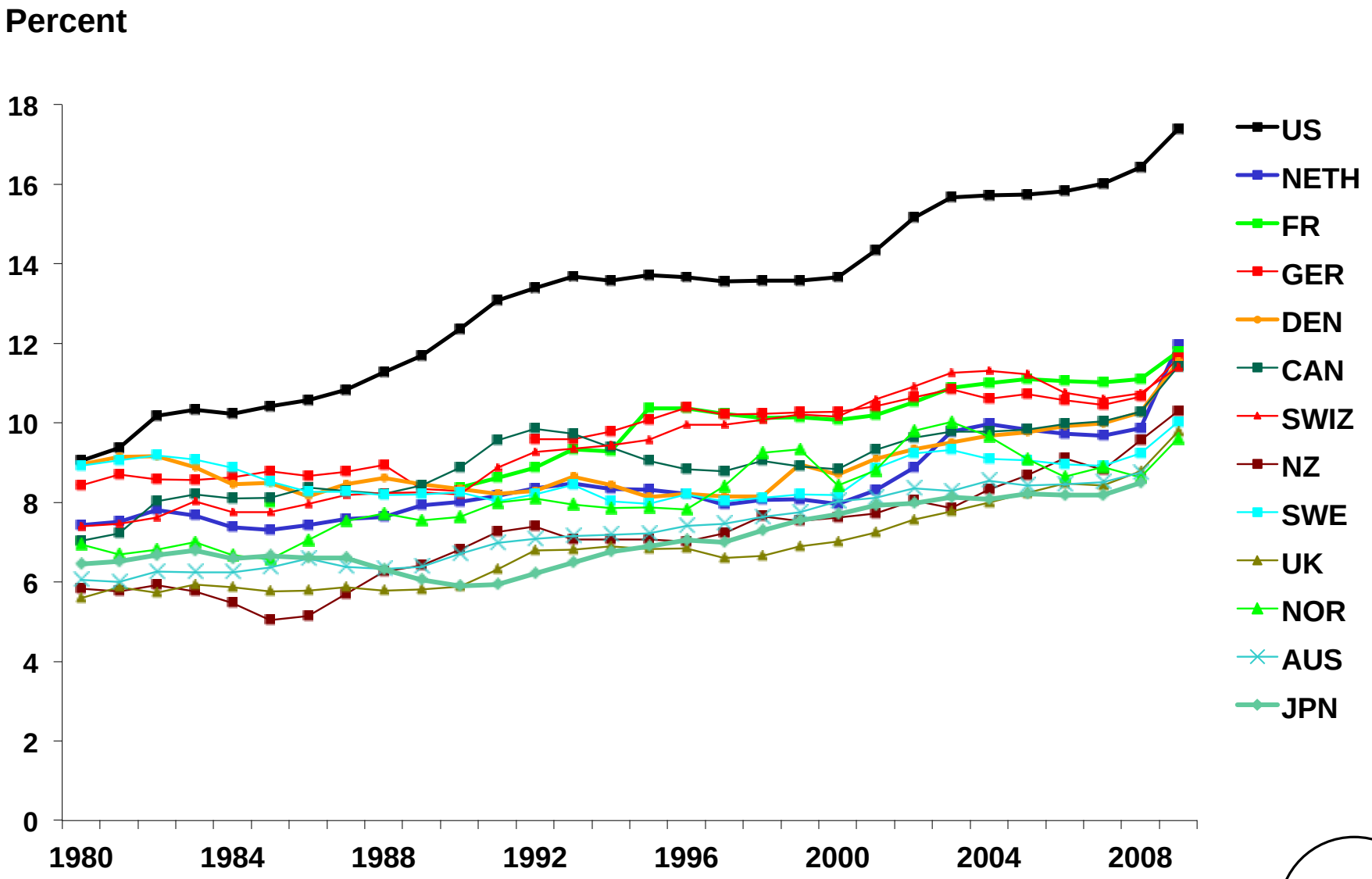
Adjusted for differences in cost of living



Source: OECD Health Data 2011 (June 2011).

THE COMMONWEALTH FUND

Health Care Spending as a Percentage of GDP, 1980–2009



GDP refers to gross domestic product.
Source: OECD Health Data 2011 (June 2011).

THE COMMONWEALTH FUND

- The median healthcare spending of the OECD member countries is 9.5% of their GDP. This is almost 18% in the USA and between 8.9-12.0% among the EU nations.

Challenges in Healthcare Systems

- Underperforming economies
- Ageing population and chronic diseases
- Rapid developments in biomedical technologies
- Increased demand for health services
- Underperforming health systems

"Unsustainable Healthcare Spending"

David Blumenthal, Driving Health System Transformation, The Commonwealth Fund 2011 International Symposium on Health Care Policy, 5 December 2011

Reforming Health Systems in Times of Austerity

EPHA Position Paper - May 2013

epha
european public health alliance

For most EU governments, health is typically the largest area of government expenditure (around 19.9% of the public budget) after social protection and it is one of the main areas of public expenditure projected to come under additional pressure as a result of demographic ageing, increases in chronic diseases, and the widening gap of health inequalities.

According to the OECD Health at a Glance Report, "Governments, under pressure to protect funding for acute care, are cutting other expenditures such as public health and prevention programmes".

Investing in health and resilience, and preserving budgets for disease prevention and health promotion should entail a greater financial reallocation for these measures. EPHA regrets the fact that 97% of health budgets is earmarked for the treatment and management of disease and only 3 % for investment in prevention, at a time when the cost of treating and managing disease keep.

THE EUROPEAN FILES

December 2013 - January 2014

TOWARDS MORE SUSTAINABLE HEALTHCARE SYSTEMS IN EUROPE

CAN EUROPE STILL AFFORD ITS HEALTHCARE MODEL?

The Financial Sustainability of Healthcare Systems

Dr James REILLY
Minister of Health, Ireland

Due to the global financial crisis, Ireland, like other EU Member States, has had to significantly reduce public spending. In the health sector, we have reduced expenditure by some 20% and comparative OECD data indicates a reduction of 8% per capita in health expenditure in 2010, compared to an average reduction of 0.6% across EU Member States.

This brings the question of the financial sustainability of healthcare systems into sharp relief. Our challenge is to reduce the cost of health services, not the quality, and as Minister for Health I have been leading on a major programme of reform to address that challenge.

Our programme of reform is set out in

By addressing pay costs and adjusting fees paid to health professionals (international data[1] suggests that general practitioners in Ireland have the highest average incomes in the OECD), we have saved well over €300 million, without sacrificing service delivery. We will continue to be rigorous in dealing with pay costs and fees which is fundamental to ensuring the long-term financial sustainability of our healthcare system.

We have introduced a number of initiatives in recent years resulting in significant reductions in the price of thousands of medicines. New agreements negotiated with industry in 2012 will result in further prices reductions, generating savings of over €400m over a three year period. The introduction of generic substitution and reference pricing in Ireland in 2013 has put in place a framework to secure further reductions. For example, just this month, we set a new reference price for atorvastatin products that was 70% lower than the price paid six months ago. These reforms secure savings for our health services as well as for hard-pressed citizens. I

We are revamping the way we fund healthcare using a Money Follows the Patient model, where each patient will be funded on an individual basis, with a corresponding charging regime for private patients. We are reforming the private health insurance market and we will introduce licensing legislation and a robust regulatory framework for healthcare providers.

The ultimate goal of the reforms in *Future Health* is to put in place a system of universal health insurance (UHI), to tackle the core and fundamental inequity in the Irish healthcare system. UHI will provide equal access to healthcare for all, based on need, not ability to pay, to realise the best health outcomes for our people. Under UHI, mandatory health insurance will cover a standard package of primary and hospital care services, including mental health services. The system will be founded on principles of social solidarity, including financial protection, choice, open enrolment, lifetime cover and community rating. We will ensure affordability by paying or subsidising the cost of insurance premiums for

European Healthcare Systems in the Present Context

Ana MATO
Minister for Health, Social Services and Equality, Spain

The preservation of the welfare state, which is of priority concern to all societies, is high on the agenda of national governments and international organisations. The significance of this issue is reflected in its growing presence in the media and in political debate[1] *[cfr. Health 2020 A European policy framework and strategy for the 21st century World Health Organization 2013, available at http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf]*.

One of the key elements of the welfare state is the health of the population, and healthcare systems make a vital contribution in this respect. In 1998, the European Parliament published a

of public governance, enhancing their efficiency and involving all stakeholders in the political debate.

In most if not all countries, health systems have significant potential for improvement; indeed, the challenges arising can sometimes be turned into opportunities. According to a study conducted in the USA, healthcare costs could be reduced by 30% without reducing quality, provided the necessary collaboration is obtained from patients and healthcare personnel, and with the introduction of measures such as joint decision taking, the coordination of care processes and their optimisation through appropriate diagnostic and therapeutic procedures.

According to the *Report on World Health – Financing Health Systems: the Path to Universal Coverage* (World Health Organization, 2010), 20-40% of total health spending is wasted, due to inefficiency. This Report identifies ten specific areas where more appropriate policies and practices could make a positive impact on spending, sometimes dramatically.

it had been scarcely represented), and the volume of contributions has increased in some State-based systems, such as that of Slovakia.

From a macroeconomic perspective, spending on health by different countries varies considerably. In 2010, the 27 countries of the European Union (EU-27) spent on average 9.0% of GDP, ranging from 12% in the Netherlands, Germany and France to 6% in Estonia and Romania. Total health spending in Spain accounted for 9.6% of GDP, which is comparable with the UK and Sweden. The public component of Spanish spending represented 7.1% of GDP, with spending per capita of 1,622 euros.[5]

Health at a Glance Europe 2012 http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf

However, although Spanish health spending is considerably less than that of some other European countries, in 2013 our system was still ranked at number five of the most efficient healthcare systems in the world, and topped the list of European countries, according to the Bloomberg

One in Four Diagnostic Catheterizations Inappropriate: NY Study

Marlene Busko | January 31, 2014

RENSSELAER, NY — One in four patients who underwent recent diagnostic catheterizations in 18 New York state hospitals to detect suspected CAD were not appropriate candidates for this procedure, based on new criteria [1], a study reports [2].

Among the patients who had undergone inappropriate diagnostic catheterization, 57% had no chest pain, no previous stress test, and a low to intermediate Framingham global CAD risk score.

"It appears that there are a lot of patients who are getting this procedure who don't really need it, and [physicians] need to look over the appropriateness criteria carefully before making a decision as to whether or not to use" diagnostic catheterization, **Dr Edward L Hannan** (State University of New York, University at Albany, Rensselaer, NY) told ***heart wire*** .

"The implications . . . are that it is an expensive procedure, and it sometimes can lead to complications [or] adverse outcomes; so . . . you shouldn't be doing it when it doesn't need to be done."

The criteria were published after the time frame of the study, Hannan acknowledged. Nevertheless, they identified wide variations in the rate of inappropriate procedures in different hospitals—ranging from 9% to 49%. This "huge variation . . . would suggest that there should be ways to get some hospitals to bring their rates down to what other hospitals are able to accomplish, regardless of what the [study] caveats are."

The study was published online January 28, 2014 in *Circulation: C ardiovascular Interventions.*

When Is a Coronary Angiogram Necessary?

Recent studies have pointed to a need for a more cost-effective use of the cardiac catheterization laboratory, the researchers write. The new appropriateness criteria provided a timely measure to see whether hospitals were sending the right patients to the cath lab for diagnostic catheterization for suspected CAD.

"The **American College of Cardiology**, the **American Heart Association**, and a few other societies convened a group to help them determine whether or not a patient should have diagnostic catheterization," Hannan explained. Using methodology developed by the RAND Corporation (Santa Monica, California), the group of experts determined criteria to classify diagnostic catheterization as appropriate, inappropriate, or uncertain (meaning that based on current

WASTE?

- In the USA, approximately 30% of healthcare costs (more than $750 billion annually) are spent on wasted care.
- This wasted care is potentially avoidable and would not negatively affect the quality of care if eliminated.

A more efficient delivery system would save 25-50%

Organization	Year	Estimate *(as percent of U.S. spending)*	Approach	Types of waste examined
PricewaterhouseCoopers	2005	**54%**	▪ Literature review ▪ Interviews with health industry executives and government officials ▪ Survey of 1,000 US consumers	▪ Behavioral inefficiencies ▪ Clinical inefficiencies ▪ Operational inefficiencies
RAND Corporation	2008	**50%**	▪ Meta-analysis of research on waste in the health care system	▪ Administrative inefficiencies ▪ Operational inefficiencies ▪ Clinical inefficiencies
McKinsey Global Institute	2008	**31%**	▪ Comparison of health care spending and income by country	▪ Spending in excess of expected level of spending based on national wealth
Institute of Medicine	2012	**30%**	▪ Meta-analysis of literature; expert interviews	▪ Unnecessary services ▪ Delivery inefficiencies ▪ High prices ▪ Unnecessary administrative costs ▪ Missed prevention opportunities ▪ Fraud and abuse
"Eliminating Waste in US Health Care" Berwick and Hackbarth (JAMA, 2012)	2011	**27%**	▪ Meta-analysis of literature	▪ Overtreatment ▪ Failures of care delivery ▪ Failures of care coordination ▪ Pricing failures ▪ Administrative complexity ▪ Fraud and abuse
NEHI	2008	**27%**	▪ Meta-analysis of expert interviews, case studies, and a review of relevant literature	▪ Emergency department overuse ▪ Antibiotic overuse ▪ Patient medication non-adherence ▪ Vaccine underuse ▪ Hospital readmissions ▪ Hospital admissions for ambulatory care-sensitive conditions ▪ Medical errors

Source: PricewaterhouseCoopers; RAND Corporation; McKinsey & Company; Institute of Medicine; Journal of the American Medical Association; NEHI

EXHIBIT 1

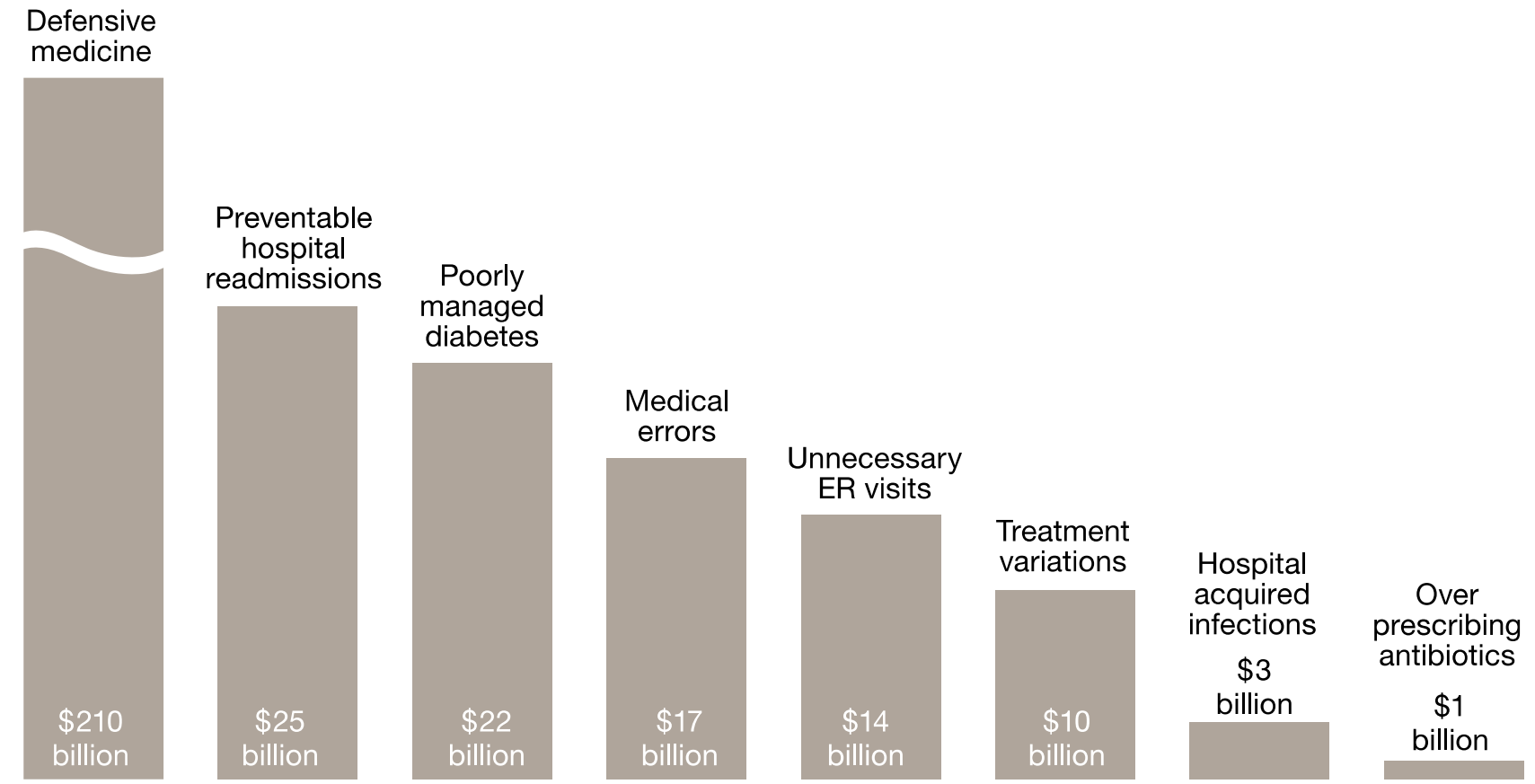
Estimates of Waste in US Health Care Spending in 2011, by Category

	Cost to Medicare and Medicaid[a]			Total cost to US health care[b]		
	Low	Midpoint	High	Low	Midpoint	High
Failures of care delivery	$26	$36	$45	$102	$128	$154
Failures of care coordination	21	30	39	25	35	45
Overtreatment	67	77	87	158	192	226
Administrative complexity	16	36	56	107	248	389
Pricing failures	36	56	77	84	131	178
Subtotal (excluding fraud and abuse)	166	235	304	476	734	992
Percentage of total health care spending	6%	9%	11%	18%	27%	37%
Fraud and abuse	30	64	98	82	177	272
Total (including fraud and abuse)	197	300	402	558	910	1,263
Percentage of total health care spending				21%	34%	47%

SOURCE Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012):1513–6. Copyright © 2012 American Medical Association. All rights reserved.
NOTES Dollars in billions. Totals may not match the sum of components due to rounding. [a]Includes state portion of Medicaid. [b]Total US health care spending estimated at $2.687 trillion.

""Health Policy Brief: Reducing Waste in Health Care," *Health Affairs*, December 13, 2012.
http://www.healthaffairs.org/healthpolicybriefs/

Exhibit 5: Annual excess costs in clinical services



Source: Institute of Medicine (1999), "The Factors Fueling Rising Healthcare Costs 2006", PricewaterhouseCoopers (2006), Medpac (2007), American Association of Endocrinologists (2006), Center for Disease Control and Prevention (2005), Solucient (2007), U.S Outcomes Research Group of Pfizer Inc (2005), National Committee for Quality Assurance (2005), Analysis by PricewaterhouseCoopers' Health Research Institute

Reducing Waste:Health Care, Long-term Care AND LONG-TERM CARE IN THE NETHERLANDS

By: Fred Lafeber and Patrick Jeurissen

Summary: The Dutch government tries to involve the population in its struggle to contain the rising costs of health care. Among its efforts is a special virtual reporting point to report 'waste'. Between late May and August 2013, 16,000 questionnaires were filled in at the virtual reporting point. Results highlight that waste seems to occur in all aspects of care. However, in acute care waste seems predominantly related to volume and the level of pricing, whereas in long-term care more waste seems to be connected to management expenses and the administrative complexity of the system. There are some indications that in The Netherlands comparatively more waste is tied to volume than in the United States where waste with respect to pricing and administrative complexity is more prevalent.

Keywords: *Reducing Waste, Health Care, Long-Term Care, The Netherlands*

Introduction

European countries are struggling to curb rising health expenditures. However, since health care services are so highly valued, many countries find it hard to openly reduce entitlements or increase the level of co-payments. Research by the European Observatory on Health Systems and Policies echoes this view, at least for those countries that are at the centre of the storms of the fiscal crisis.[1] Keeping in mind the potential effects of more restrictive global budgets on things such as longer waiting lists, measures to directly address waste garner greater attention. Tackling waste also fits in with broader policy agendas in health, such as creating sustainable health systems and related to this, increasing the overall efficiency of health system functioning.

Indeed, Berwick and Hackbarth[2] claim that reducing waste is the largest and smartest opportunity for developing an affordable health system. They distinguish six categories of waste: 1) health care delivery failures; 2) failures of coordination (e.g. fragmented care); 3) overutilisation; 4) administrative complexity; 5) pricing failures; and 6) fraud and abuse. The authors estimate that between 21% and 47% of all US health care costs are being 'wasted'. In a recent study, former Dutch health care minister Ab Klink estimates that a combined strategy of reducing overutilisation, increasing integrated care and stimulating shared-decision making can add-up to annual savings of €8 billion in The Netherlands – almost 20% of the total budget for acute care.[3]

Fred Lafeber is project leader for waste in long-term care and **Patrick Jeurissen** is chief of the strategy group at the Ministry of Health, Welfare and Sport, the Netherlands. Email: fn.lafeber@minvws.nl

In The Netherlands, the volume of acute care seems to be a main issue. This fits with some results of the Survey of Health, Ageing and Retirement in Europe (SHARE) surveys that show that the number of physician visits seem to have increased more in The Netherlands compared to certain other countries in Europe, perhaps indicating an increase in overutilisation and more prescriptions.

Eurohealth incorporating Euro Observer — Vol.19 | No.4 | 2013

Choosing Wisely-2012

- An initiative of the ABIM Foundation, *Choosing Wisely* is focused on encouraging physicians, patients and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary, and in some instances can cause harm. More than 50 specialty societies have now joined the campaign, and 30+ societies will announce new lists in late 2013 and early 2014.

Choosing Wisely®

An initiative of the ABIM Foundation

American College of Physicians

Five Things Physicians and Patients Should Question

ACP American College of Physicians® INTERNAL MEDICINE | *Doctors for Adults*

1 Don't obtain screening exercise electrocardiogram testing in individuals who are asymptomatic and at low risk for coronary heart disease.

In asymptomatic individuals at low risk for coronary heart disease (10-year risk <10%) screening for coronary heart disease with exercise electrocardiography does not improve patient outcomes.

2 Don't obtain imaging studies in patients with non-specific low back pain.

In patients with back pain that cannot be attributed to a specific disease or spinal abnormality following a history and physical examination (e.g., non-specific low back pain), imaging with plain radiography, computed tomography (CT) scan, or magnetic resonance imaging (MRI) does not improve patient outcomes.

3 In the evaluation of simple syncope and a normal neurological examination, don't obtain brain imaging studies (CT or MRI).

In patients with witnessed syncope but with no suggestion of seizure and no report of other neurologic symptoms or signs, the likelihood of a central nervous system (CNS) cause of the event is extremely low and patient outcomes are not improved with brain imaging studies.

4 In patients with low pretest probability of venous thromboembolism (VTE), obtain a high-sensitive D-dimer measurement as the initial diagnostic test; don't obtain imaging studies as the initial diagnostic test.

In patients with low pretest probability of VTE as defined by the Wells prediction rules, a negative high-sensitivity D-dimer measurement effectively excludes VTE and the need for further imaging studies.

5 Don't obtain preoperative chest radiography in the absence of a clinical suspicion for intrathoracic pathology.

In the absence of cardiopulmonary symptoms, preoperative chest radiography rarely provides any meaningful changes in management or improved patient outcomes.

Choosing Wisely®

An initiative of the ABIM Foundation

American College of Cardiology

AMERICAN COLLEGE of CARDIOLOGY

Five Things Physicians and Patients Should Question

1 Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.

Asymptomatic, low-risk patients account for up to 45 percent of unnecessary "screening." Testing should be performed only when the following findings are present: diabetes in patients older than 40-years-old; peripheral arterial disease; or greater than 2 percent yearly risk for coronary heart disease events.

2 Don't perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.

Performing stress cardiac imaging or advanced non-invasive imaging in patients without symptoms on a serial or scheduled pattern (e.g., every one to two years or at a heart procedure anniversary) rarely results in any meaningful change in patient management. This practice may, in fact, lead to unnecessary invasive procedures and excess radiation exposure without any proven impact on patients' outcomes. An exception to this rule would be for patients more than five years after a bypass operation.

3 Don't perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Non-invasive testing is not useful for patients undergoing low-risk non-cardiac surgery (e.g., cataract removal). These types of tests do not change the patient's clinical management or outcomes and will result in increased costs.

4 Don't perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.

Patients with native valve disease usually have years without symptoms before the onset of deterioration. An echocardiogram is not recommended yearly unless there is a change in clinical status.

5 Don't perform stenting of non-culprit lesions during percutaneous coronary intervention (PCI) for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI).

Stent placement in a noninfarct artery during primary PCI for STEMI in a hemodynamically stable patient may lead to increased mortality and complications. While potentially beneficial in patients with hemodynamic compromise, intervention beyond the culprit lesion during primary PCI has not demonstrated benefit in clinical trials to date.

www.choosingwisely.org/

- Choosing Wisely Canada will be operational this fall under the umbrella of the Canadian Medical Association and guided by the University of Toronto. At least eight Canadian specialty societies will release lists of five tests and procedures to question and others are expected to follow.
- The Netherlands, Germany, United Kingdom, Denmark, Italy, New Zealand, Australia and Israel have all expressed interest in implementing the campaign.

“High Value Care”

- American College of Physicians (ACP) started a movement called “High Value Care”.
- The College states that: “ACP is committed to help bend that cost curve and to reduce the unsustainable financial burdens to USA healthcare system”.
- Two important priorities
  - Helping physicians to provide the best possible care to their patients.
  - Simultaneously reducing unnecessary costs to the healthcare system.

Steps Toward High Value, Cost-Conscious Care

- **Step one:** Understand the benefits, harms, and relative costs of the interventions that you are considering
- **Step two:** Decrease or eliminate the use of interventions that provide no benefits and/or may be harmful
- **Step three:** Choose interventions and care settings that maximize benefits, minimize harms, and reduce costs (using comparative-effectiveness and cost-effectiveness data)
- **Step four:** Customize a care plan with the patient that incorporates their values and addresses their concerns
- **Step five:** Identify system level opportunities to improve outcomes, minimize harms, and reduce healthcare waste.

http://hvc.acponline.org/

Curriculum for Educators, Residents, and Students

Six Curriculum Topics:

1. Eliminating Healthcare Waste and Over-ordering of Tests
2. Healthcare Costs and Payment Models
3. Utilizing Biostatistics in Diagnosis, Screening and Prevention
4. High Value Medication Prescribing
5. Overcoming Barriers to High Value Care
6. High Value Quality Improvement

“Best Care at Lower Cost”

- Institute of Medicine also addressed the issue in a recent report; “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America”.
- They recommended,
  - use of science and informatics (evidence based),
  - improved patient-clinician partnership,
  - value-based incentives and culture change (starting with leadership) for best care at lower cost.

www.iom.edu/

The last word from Stephen C. Schimpff

- The most important issue in healthcare is lack of time – time to listen and time to think.
- The result is less than adequate care, certainly not humane care, not healing care and very high costs.

http://medicalmegatrends.blogspot.com