Ethical Perspectives
On Health Care Reform

# THE ETHICS OF COST CONTROL

## *Wasteful Treatments Undermine Health Care for All*

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Cost control needs to occupy a more central place in the everyday health care ethics agenda. It is not an easy task to clarify and communicate a sound ethical foundation and framework for effective cost-control efforts, but it is a major task of the times.

As has become abundantly clear to most people who are familiar with health care trends and policy planning, the constantly rising cost of health care must be controlled if the United States is going to have a sustainable system of high-quality health care for all.

But, in U.S. culture generally and in health care organizations and professions specifically, we do not yet regularly highlight the waste and the health risks involved in doing more than needed. We do not yet emphasize the ethical imperative of avoiding unnecessary interventions. We have not yet developed guidelines with a strong enough rationale and with sufficient clarity to assist providers, patients and payers in understanding the differences between what is needed and what is excessive. We do not yet regularly emphasize controlling health care cost as a fundamental ethical responsibility.

The health economist Uwe Reinhardt made the point this way:

> "Health spending in the United States has doubled every 10 years during the last four decades. As health spending grows, year after year, roughly twice as fast as the payroll that supports private health spending in this country, Americans sooner or later will have to confront the hard questions about access to expensive treatment. ..."[1]

Federal budget planning and efforts to reduce the federal deficit inevitably focus on the cost of Medicare, and both companies and individuals paying for private insurance feel the constant burden of that expense.

One of the key cost control mechanisms in the Patient Protection and Affordable Care Act is the establishment of the Independent Payment Advisory Board. Composed of 15 full-time members to be appointed by the president and confirmed by the Senate for six-year terms, the board is responsible for proposing recommendations to reduce the per-capita rate of growth of Medicare spending. Though limited by several restrictions on the kinds of proposals it can make, the advisory board is expected to have substantial influence on the way Medicare spending targets are met, since the law also establishes a timetable by which Congress must consider and vote on the board's proposals.

A Kaiser Family Foundation paper on this advisory board notes: "The establishment of the Board represents the first time that the Medicare program will be subject to spending limits, with statutory requirements to achieve savings targets."[2]

The advisory board also has the responsibility for making recommendations for slowing the growth in national health spending without harming quality. Henry Aaron, Ph.D., senior fellow for economic studies at the Brookings Institution, calls the establishment of this board "Congress's

good deed."[3] While it is not clear how effective the Affordable Care Act will be in controlling the cost of health care spending, the legislation does include (in Aaron's words):

> "... a broad and potentially powerful portfolio of cost-control instruments, containing virtually every method that analysts have advanced for slowing growth of spending in a rational fashion — accountable care organizations, comparative-effectiveness analysis, bungled payments, value-based insurance design, limits on the exclusion of employer-financed premiums from personal income tax, and health insurance exchanges to promote competition among insurance plans."[4]

It is not yet clear which of these methods are (most) effective in controlling health care costs, but their inclusion in the Affordable Care Act, along with the establishment of the advisory board, indicate the extent to which cost control is recognized as a necessary part of any real health care reform.

There is no doubt that health care cost control is a very difficult task. Daniel Callahan, president emeritus and senior research scholar at the Hastings Center, has described it as a conundrum for politicians and the public alike.

> "It is technically difficult to figure out how to do it effectively and equitably ... And it is difficult ethically because it means taking from people what they think they need, rightly or wrongly, hurting them for some higher good. President Obama said in his State of the Union address that 'the only way to tackle our deficit is to cut excessive spending.' But what is 'excessive' for some is legitimate profit for others, and perhaps marginally but desirably life-prolonging for others."[5]

As some European health care systems get better outcomes at lower costs, it is reasonable to conclude that there is much that is excessive in our system. Higher cost and better quality do not go hand in hand. In fact, there is evidence indicating that, at times, reducing some costly interventions improves the quality of care.

The ability of Americans to receive needed care and treatment is, ultimately, closely related to the cost of health care. Given all the other competing needs and interests, there is not an unlimited financial commitment that we, as individuals, as employers and as a society, are able or willing to make for health care. If the cost of health care continues to escalate rapidly, more and more Americans will be at risk of not being able to afford the treatment that they need — or going without something else also very important in their lives.

The success of health reform efforts requires a clear recognition of the ethical responsibility to control cost. It also requires carefully considered criteria for understanding the differences between appropriate and inappropriate cost-control measures. In the effort to clarify and explicate the ethics of cost control, some of the considerations made below may be useful.

### NO MORE THAN WE NEED

In the statement quoted above, Reinhardt connected the cost of unsustainable health care spending to expensive *treatments*. It is not primarily "waste, fraud, and abuse" that continually drive up the cost of health care in the U. S. Nor is it primarily the fees paid to providers. Rather, it is the cost of the diagnostic and treatment interventions that are promoted, requested, ordered and provided. To control cost and to prevent the waste of health care resources, we need to focus on the nature of these interventions.

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Justice advocates have long argued that assured access to health care for everyone is a necessary characteristic of a just society. Something essential to a life of human dignity is missing if people do not has access to basic and essential health care services, regardless of their social or economic condition and regardless of their health history. The goal of increased and improved ac-

cess is, as it should be, a major driving force behind efforts to improve the health care system. We will be able to achieve this goal, however, only if we are able to control spiraling costs.

A 2010 Michigan Public Radio story about the Native American tradition of harvesting wild rice included a comment about returning some seed to the water on the last day of the harvest, to reseed for future use. Roger LaBine, a Lake Superior Chippewa, explained: "And say thank you ... give us all that we need and no more than we need so that we can carry this on."

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In a just health care system, both parts are important — "all that we need" and "no more than we need." We can only hope to have all that we need if we do not waste resources on what we do not need. The "no more than we need" side of resource use may be the greater challenge in our health care culture and the part of the ethical mandate that we need to highlight and explicate in more detail if we are to achieve a just, high-quality and sustainable system. Because providing "more than we need" limits the ability to meet true health care needs, unnecessary treatment and unnecessarily expensive treatment are major ethical concerns.

Too often, however, a commitment to cost control has not been recognized as a necessary element of just health care but seen as a threat to meeting a patient's needs. This is reflected in the view of many that an emphasis on cost control means withholding needed treatment. The quick and negative use of the term "rationing" when the cost of the treatment is discussed is an example of the tendency to see a conflict between a focus on the patient's needs and a commitment to controlling the cost of treatment. This is an inadequate view of the ethics of patient care.

The standards of medical ethics taught to physicians have often emphasized patient rights and the importance of putting patients' needs first. Less attention has usually been given to the use of resources. This is being corrected, however, and some recent statements on the meaning of medical professionalism make it very clear that the obligation to put the patient's welfare first does not mean that the professional is justified in ignoring cost. The 2002 document, "Medical Professionalism in the New Millennium: A Physician Charter," puts the dual responsibility this way: "While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources."[6]

Controlling the cost of treatment is not in conflict with the principle of the primacy of patient welfare just as controlling the cost of treatment is not in conflict with guaranteed access to health care for all. Consider the ethics of controlling the cost of treatment, first, in relationship to respect for patient rights and, secondly, in terms of the larger context of unnecessary care in the U.S. health care system.

### THE COST OF TREATMENT AND PATIENT RIGHTS

Nothing in health care ethics has received more attention over the last 40 years in the U.S. than patient rights. For the most part, the emphasis has been more on the extent of patient rights than on the limits of patient rights. That is, we have more often highlighted what patients have a right to than what they do not have a right to. That is understandable, given the history and context of doctor-patient relationships. As we devote more explicit attention to the cost of treatment in relationship to patient rights, however, it may be necessary to point out and even highlight what patients do not have a right to.

Taking seriously the ethical responsibility to control cost in the treatment of individual patients does not immediately mean withholding treatment that is expected to provide real benefit to a patient simply because it is costly or simply to save resources. That is true rationing and, while rationing should not be ruled out in all cases, it is not the place to start and it is not compatible with the intent of the Patient Protection and Afford-

able Care Act. The ethics of controlling the cost of treatment, of avoiding waste in the allocation of resources, starts, rather, with "unnecessary treatment" and "unnecessarily expensive treatment."

The first priority in limiting the use of health care resources is to eliminate or reduce nonbeneficial or futile treatment, those uses of health care services that, based on the best available evidence, predictably fail to improve outcomes. It is not enough to say that physicians are "not obligated to provide" such treatment; they should not present such treatment as an option for patients to consider and they should not provide it even if the patient requests or demands it.

Any judgment that treatments are "unnecessarily expensive" or a "waste of resources" should not be based simply on the dollar amount involved in a course of treatment, but, rather, on a consideration of the relationship of the cost to the expected medical benefit. This means high cost for major expected benefit is normally an appropriate use of resources, but high cost for no real expected benefit is a waste of resources. Indeed, minor cost for no real expected benefit is a waste of resources.

The concern about cost is not primarily about the cost to the patient out of pocket. While this is of obvious interest to patients and something they should be informed about in making consent-related decisions, it is not the primary focus of the ethics of cost control. In terms of the justice of the health care system, the right question is not whether a treatment is covered by insurance but whether it is necessary and beneficial and whether there is a less expensive alternative available with similar benefits.

The concern about the cost of treatment is not primarily about the cost to the individual provider organization. Limiting unreimbursed cost to the organization is an important concern as well, but the need to avoid unnecessary or wasteful treatment is about the sustainability of the system as a whole. (The other side of this coin is that organizations need to protect against promoting a type of treatment largely because it is a revenue producer.)

Without going into a full discussion of the nature of each of the following points, it is possible to summarize some relevant considerations related to patient rights and the cost of treatment.

- All individuals should have access to a basic and essential level of health care services, regardless of their ability to pay.
- An informed patient with decision-making capacity ordinarily has the right to decline unwanted treatment, regardless of the nature of that treatment and regardless of the benefit that the treatment is expected to provide.
- In order for their consent-related decisions to be informed, patients/surrogates need to know treatment options, expected benefits and potential risks and alternatives to the proposed treatment. In order for their consent-related decisions to be fully informed, patients/surrogates should be given information on the relative cost of different treatment options, even when these treatments are covered by insurance.
- Patients who request information about the cost of proposed treatment have an ethical right to that information, and an informed patient's decision to decline a particular treatment because it is judged too expensive should be respected.
- Patients do not have a right to receive the treatment they think best if the physician thinks that the treatment is not medically indicated by the patient's condition and is not expected to provide benefit.
- Patients ordinarily should not be provided a more expensive (form of) treatment, even if they request it, when the less expensive option is the standard of care, is available and is expected to provide similar or better benefits compared with the more expensive treatment in this case.

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To speak of patient rights in making treatment decisions is to speak, at the same time, of clinician responsibilities. As cost-consciousness becomes a more central consideration in clinical ethics, standards like the following will likely become

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more widely recognized and accepted.

- Patients should not receive treatment that, in the clinician's medical judgment, is not indicated by the patient's condition and is not expected to provide benefit — even if patients insist upon this treatment.
- Clinicians have a responsibility to be well informed about the cost of the kinds of treatments and tests that they most commonly order or recommend. As a general rule, the least costly treatment should be provided unless there is "substantial evidence that a more costly intervention is likely to yield a superior outcome."[7]

The importance of the just allocation of resources in the system as a whole requires that ethical guidelines related to the cost of treatment be integrated into the clinical setting. As they begin to give cost control a more central place on their agenda, one of the tasks of clinical ethics committees in hospitals and other health care provider organizations is to keep informed of the evolving understanding of the ethics of cost control and to seek ways of applying this understanding locally.

### UNNECESSARY AND UNNECESSARILY EXPENSIVE TREATMENT

In his recently published *Over-Diagnosed: Making People Sick in the Pursuit of Health*, H. Gilbert Welch, along with two colleagues at the Dartmouth Institute for Health Policy and Clinical Practice, provides a detailed argument that many of the efforts to screen well people for potential diseases does much more harm than good. The following is a summary of his conclusions after a study of screening programs for several different diseases.

> "I believe overdiagnosis is the biggest problem posed by modern medicine. It is a problem relevant to virtually all medical conditions. It has led millions of people to become patients unnecessarily, to be made anxious about their health, to be treated needlessly, and to bear the inconvenience and financial burdens associated with overdiagnosis. It has added staggering costs to our already over-burdened health-care system. And all the forces that helped create and exacerbate the problem — financial gain, true belief, legal concerns, media messages, and self-reinforcing cycles — are powerful obstacles to fixing it."[8]

This is one voice among many now calling attention to the tendency to do more than needed and to the financial incentives that reinforce overtreatment and overly expensive treatment. The *New York Times* economics columnist David Leonhardt picked *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer* by Shannon Brownlee as the best economics book of 2007. Leonhardt describes *Overtreated* as "the best description I have yet read of a huge economic problem that we know how to solve — but is so often misunderstood."[9]

In some important ways, the normal economic rules do not apply in health care. The number and types of services provided are not dependent upon the demand or the need. Often, in fact, it works in the opposite way: the demand expands to consume the supply of resources. Over the years, the work of researcher Jack Wennberg, MD, and his colleagues at Dartmouth has demonstrated the extensive differences in treatment used for the same conditions in different locations around the country. Part of the explanation appears to be the supply-driven demand nature of health care. For example, more catheterization labs have regularly led to more catheterizations and to more bypass surgery.

One common proposal for controlling health care costs is comparative effectiveness research. Groups like the Commonwealth Fund have projected that one of the best options for achieving savings and value in health care is the establishment of an effective center for evaluating which treatments work best for which patients. One of the most important demonstrations that more

treatment and more expensive treatment do not mean better treatment is found in a major study published in *The Annals of Internal Medicine* in 2003. Elliott Fisher et al. (Dartmouth) showed that some hospitals regularly spend more money (do more tests and procedures) than other hospitals for patients with basically identical health conditions.[10]

In general, those hospitals that spend more do not have higher quality outcomes. Brownlee reported further: "But it was the outcomes ... that proved to be the most startling finding ... patients who went to hospitals that spent the most — and did the most — were 2 to 6 percent more likely to die than patients who went to hospitals that spent the least."[11]

In his discussion of the role of physicians in the process of controlling health care costs, medical ethicist Howard Brody, MD, made the following observation: "What we now know about regional variation in costs within the United States suggests that nearly one third of health care costs could be saved without depriving any patient of beneficial care. ..."[12]

Brownlee also argued that the primary need may not be for the development of good clinical data, since much of the data already exists. The key problem is the way the health care economy works, the financial incentives that encourage unnecessary and more expensive treatment. The solution is not just to have good clinical data. It is to understand and to change the economics of the system.

The financial incentives are often perverse. As many have long recognized, the payment system reimburses much more for invasive procedures and much less for the care that manages chronic diseases or prevents them. And when hospitals attempt to provide better care at less expense, they often suffer financially. In some cases, treating a heart-attack patient with drugs alone and no surgery is just as effective as angioplasty. But it may very well lead to a financial loss for the hospital, while angioplasty is likely to contribute positively to the bottom line.[13]

It is no surprise, therefore, that those whose responsibility it is to ensure financial security for the organization think more in terms of attracting paying patients for income-producing services (and reducing money losers) than they do in terms of avoiding unnecessary or unnecessarily expensive treatment. Such is the nature of incentives that make it so difficult to implement consistently a commitment to high quality cost-effective care.

There has also been a strong interest in recent years in the impact of industry on medical treatment decisions. The marketing practices of pharmaceutical and medical device companies have led, at times, to the use of more expensive treatments than necessary. The relationships, including financial relationships, that industry has established with clinicians, with academic medicine, with continuing medical education, with clinical researchers, with medical journals, with clinical practice guideline writers, with medical specialty associations, with patient advocacy groups, etc., have come to be recognized as serious threats to the integrity of the medical profession and to the practice of cost-effective medicine.[14]

This growing awareness of the pervasive direct and indirect impact of marketing on clinical decision-making has led to the development and implementation of more effective conflict of interest policies than existed in most organizations previously.[15] Much work remains to be done and the task of reducing and managing conflicts of interest is likely to remain a high priority item on the organizational ethics agenda for some time to come. It is one essential part of the local effort to implement the ethics of cost control.

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SHANNON BROWNLEE

### COST, ETHICS AND HEALTH REFORM

It appears inevitable that the growth rate of Medicare spending will be reduced. There will be cuts made. The real questions are how the cuts that are made will affect Medicare recipients and how they will affect the health care system generally. Cuts that do not distinguish between services

that provide true benefit and services that provide little or no benefit will do more harm than good.

The Affordable Care Act includes a variety of cost-control instruments which, if implemented well, can reduce unnecessary care and unnecessarily expensive care without depriving individuals of needed care. Whether they will be implemented well depends in significant part upon the understanding in the American culture regarding the kinds of treatment clinicians and health care organizations should provide and what patients have "a right" to. And the way the ethics of cost control is explicated for clinicians and for health care organizations is important is helping to shape that cultural understanding.

This article is intended to provide an indication, not a definitive description, of what it means when cost control truly becomes a high ethical priority in both clinical and organizational ethics, a priority that is attended to in an informed, sensitive and consistent manner. It remains to be seen what the full implications will be, but it is time that we find out.

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