ACP AMERICAN COLLEGE OF PHYSICIANS®
INTERNAL MEDICINE | Doctors for Adults

Q&A on *How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?*

1. Is ACP advocating rationing?

No, we are advocating using health care resources effectively, efficiently and *rationally.* There is a difference between medical rationing, in which decisions are made about the allocation of scarce medical resources and who receives them, and *rational* medical decision-making, by which judicious choices are made among clinically effective alternatives. Engaging the public in a discussion of how to conserve and allocate resources effectively, based on evidence of their *value,* would result in more judicious use of limited resources, and *help the United States avoid the overt medical rationing.*

Every country makes decisions on how to allocate available health care resources, but their approaches vary widely, reflecting the different political and cultural conditions in each country. The United States limits access to services based on access to affordable health insurance coverage, insurance company decisions on covered benefits and cost-sharing, socio-economic and racial and ethnic characteristics of the population being served, the availability of physicians and health care facilities, among other factors.

Yet the U.S. has largely failed to address the reality that health care spending is increasing at a rate the country can't afford. Total US health care spending, already the highest in the world, is projected to almost double over the next decade.[i] Yet as much as *$700 billion* of health care spending *per year,* 5 percent of the nation's GDP, *is* wasted *on tests and procedures that do not improve health outcomes.* [ii-iii] Spending more on care is not necessarily "better," if much of what one gets is unnecessary or even dangerous, especially if it keeps someone else from beneficial care. This is a societal issue that transcends medical care itself—how much should we as a society spend using public funds on health care versus education, the environment, or the defense of our country?

2. This is a divisive issue, why is ACP raising it?

The contentious debate over health care reform has become polarized over whether or how the United States should 'ration' care, a term that is poorly understood, emotionally-driven, and not conducive to reaching consensus. Rationing conjures up images of shortages, delays in obtaining treatment, long waiting lines, and government bureaucrats coming between patients and their physicians. A better way is to engage the public in a discussion of how to allocate resources in a way that respects American values. As medical professionals, physicians have a responsibility to help lead a dialogue on judicious and effective use of limited resources.

25 MASSACHUSETTS AVENUE, NW, SUITE 700, WASHINGTON, DC 20001-7401, 202-261-4500, 800-338-2746
190 NORTH INDEPENDENCE MALL WEST, PHILADELPHIA, PA 19106-1572, 215-351-2400, 800-523-1546, www.acponline.org

3. Who should decide on what resources will be available?

Democratically elected countries have a responsibility to develop ways to determine the allocation of public resources that have broad public support; such decisions in the U.S. cannot and must not be "imposed" on the population without the consent of the people.

At the patient encounter level, physicians—in consultation with patients— have a responsibility to use health care resources wisely, based on evidence of safety and effectiveness, the particular needs and circumstances of the patient, and with consideration of cost. At the societal level, allocation decisions should be informed by evidence on the value of different interventions, be in accord with societal values, and reflect moral, ethical, cultural, and professional standards.

4. So, how *specifically* should the United States allocate health care resources?

- Sufficient resources should be devoted to developing needed data on clinical and cost-effectiveness of medical interventions for comparative, evidence-based evaluations.
- There should be a transparent and publicly acceptable process for making allocation decisions with a focus on medical efficacy, clinical effectiveness, and need, with consideration of cost based on the best available medical evidence.
- The public, patients, physicians, insurers, payers, and other stakeholders should have opportunities to provide input to allocation decision-making at the policy level.
- Multiple criteria should be considered in determining priorities for health care resources including patient values, potential benefit, safety, equitable access, quality of life, and impact on families and caregivers.
- Allocation decisions should be in accord with societal values and reflect American moral, ethical, cultural, and professional standards.
- Allocation decisions should not discriminate against a class or category of patients.
- The allocation process should be flexible enough to address variations in regional needs and accommodate special circumstances.
- Individuals should be involved in making informed decisions about their own care and share in decision-making responsibility.
- Patients and physicians should be provided with objective and understandable information about the benefits and costs of different treatments.
- Patient cost-sharing should vary to reflect value.

- People should be able to purchase additional health care services and coverage at their own expense.

- Medical liability reforms are needed to decrease the practice of defensive medicine.

- The resource allocation process and priority setting should be periodically reviewed to reflect evolving medical and societal values, changes in evidence, and to assess for any cost shifting or other unwanted effects.

5. How does ACP's approach differ from that of other countries that overtly ration health care services?

ACP recommends an approach that respects distinctive American values, with a strong emphasis on empowering patients to make decisions with their physicians based on the best available evidence, rather than the government imposing such decisions.

6. But, aren't you advocating using comparisons of clinical effectiveness and cost to ration services?

No, ACP believes that use of such evidence to *inform* clinical decisions and coverage decisions would improve outcomes and help conserve limited health care resources, goals that are complementary and not in conflict with each other. Health resource allocation decisions should be based on the best available medical evidence. They should focus on medical efficacy and clinical effectiveness but should also consider cost so that patients obtain services that are of the greatest value. We consider comparative effectiveness data to be an important tool for physician-patient decision-making regarding alternative treatments and for making resource allocation decisions on a national or systems basis.

7. Isn't the scientific evidence pretty weak or non-existent for many treatments?

The evidence often is unclear. Much comparative effectiveness research focuses solely on evaluating relative clinical differences without considering cost. Most studies of comparative effectiveness evaluate new medications and therapies compared with no intervention or a placebo. They don't compare new and existing treatments to each other or to non-medical interventions. We strongly support devoting sufficient resources to develop a strong evidence base to determine what good-quality is, what is clinically effective, and what is clinically effective with proper consideration of cost.

8. Isn't the physician's primary responsibility to the patient as opposed to considering the broader needs of society?

Resource allocation decisions are policy decisions that are most appropriately made at the system level, not at the bedside. Physicians should use resources wisely and help ensure that resources are equitably available.[iv] Professionalism involves commitments to improving quality of care,

improving access to care, eliminating discrimination in health care, and justly distributing finite resources. [v]

9. What's the difference between rationing of scarce resources like organs for transplantation versus allocating other health resources?

For specific services that are in great shortage, like hearts or kidneys for organ transplantation, we recommend following a process like that used by United Network for Organ Sharing (UNOS) in which priority of recipients is based on objective evaluations to determine which patients are most likely to benefit. You could call that kind of process *rationing*. However, setting priorities for other health resources requires a process involving multiple criteria that should be in accord with societal values and reflect moral, ethical, cultural, and professional standards. Here ACP is talking about making judicious choices among alternative clinically effective treatments.

10. You would allow patients to obtain services even if they are unnecessary, inappropriate, harmful, and/or unproven as long as they spend their own money. Doesn't this conflict with your goal to use resources wisely and judiciously?

The United States has a long history of individualism and of preserving the freedom of individuals to make their own choices. Individuals are not entitled to have society pay for care that is not supported by the evidence, but they may elect to use their own personal resources to pay for such services. The potential that this could result in inequitable treatment of different persons based on their ability to pay can be mitigated by ensuring that all Americans, without regard to ability to pay, have access to comprehensive and evidence-based health insurance coverage.

11. How would ACP deal with a patient who wants a test or treatment that you think is unnecessary or ineffective?

Engaging patients in decision-making with their own personal physician about the evidence to support different treatment options will lead to fewer instances of patients "demanding" unnecessary care. However, physicians have an ethical obligation "to do no harm" and are not obligated to provide care that is unnecessary or impairs the patient's ability to obtain effective therapy. Involving the doctor and patient in shared decision-making is a way to ensure that treatment decisions are optimally aligned with patient values and preferences, prevent unwanted treatments and procedures, and avoid unnecessary health care costs.

Research has shown that decision aids improve people's knowledge of options, create realistic expectations of benefits and harms, reduce difficulty with decision-making, and increase participation in the decision-making process. Patients should have access to information about the effectiveness of medical tests and procedures. Improved transparency with public access to information about the qualifications and performance of physicians, hospitals, and other providers of health care services would also help patients in their decision-making. Patients are less likely to choose interventions, such as invasive surgery, when they are fully informed not

necessarily because they are trying to save money but rather because they may have different values, preferences, and incentives than their physicians.

12. Without medical liability reform, won't physicians provide unnecessary tests and order procedures to protect themselves from being sued?

Defensive medicine results in inefficient use of health care resources and adds unnecessarily to health care costs, including physician costs for malpractice insurance. Tort reform and changes in legal standards concerning professional liability are needed to remove a major impediment that inhibits physicians from responsibly ordering tests and procedures based primarily on clinical and cost-effectiveness in accord with practice guidelines.

13. Who should perform research on comparative effectiveness, government or the medical profession?

The Patient-Centered Outcomes Research Institute, the Agency for Healthcare Research and Quality (AHRQ), and the National Institutes of Health (NIH) as well as the medical profession all have major roles to play. ACP has been developing evidence-based clinical guidelines and encouraging use of these guidelines for almost 30 years. ACP also publishes a continually updated, evidence-based reference of internal medicine practices and offers the Physicians' Information and Education Resource (PIER), a Web-based decision-support tool designed for rapid point-of-care delivery of up-to-date, evidence-based guidance for clinicians, free to its members. ACP Guidelines are also published in ACP Medicine.

ACP is launching the *High-Value, Cost-Conscious Care Initiative*, a broad program that connects two important priorities for ACP: helping our physicians to provide the best possible care to their patients, and simultaneously reducing unnecessary costs to the health care system. This initiative will provide physicians and patients with evidence-based recommendations for specific interventions for a variety of clinical problems. The *Initiative* will assess benefits, harms, and costs of diagnostic tests and treatments for various diseases to determine whether they provide good value -- medical benefits that are commensurate with their costs and outweigh any harm. The February 1, 2011 issue of the *Annals of Internal Medicine*, ACP's peer-reviewed, flagship journal, will publish two important papers related to the *High-Value, Cost-Conscious Care Initiative.*

Other organizations also develop clinical guidelines, but there is much variation in methodology and guidelines that can be conflicting. Consequently, ACP has supported the creation of an independent, trusted entity to facilitate the development and sharing of evidence-based data on clinical effectiveness and comparative effectiveness.

14. How does ACP expect to achieve a national consensus about allocating health resources?

The United States has no choice but to confront the question of how limited resources can be allocated rationally and judiciously. Failure to address this issue now will lead to continued cost

increases that will make health care unaffordable and likely lead to explicit medical rationing; addressing it now can help bring costs under control more gradually in a way that enjoys the support of the American people and helps prevent explicit rationing in the future.

Our paper is offered to stimulate an informed national discussion that is transparent, understandable to the public, and politically acceptable. We urge public policymakers to begin discussion now so that a process can be developed for the United States that will be reasonable, understandable, and publicly acceptable and will avoid or minimize actual rationing. We suggest three questions to begin this discussion:

1. How can equitable and just decisions be made on the allocation of limited health care resources, and who should be involved in making such decisions?

2. What resource allocation mechanisms should be considered?

3. How can we best develop a process for health resource allocation decision-making, and how can public support for the process be maximized?

ACP's paper explores these questions in order to encourage a non-partisan dialogue on how best to ensure that spending on health care is sustainable and doesn't bankrupt our country. Consideration of these questions also ensures that decisions on allocating resources are based on evidence and made in a way that has the support of the public and respects distinctly American values.

---

[i] **Office of the Actuary**. Centers for Medicare and Medicaid Services. National Health Expenditures Projections 2009-2019 (September 2010). Accessed at http://www.cms.gov/NationalHealthExpendData/Downloads/NHEProjections2009to2019.pdf

[ii] **Orszag PR**. Increasing the Value of Federal Spending on Health Care. Testimony to Committee on the Budget, U.S. House of Representatives July 16, 2008. Accessed on 13 Sept 2010 at http://budget.house.gov/hearings/2008/07.16orszag.pdf

[iii] **Fisher ES, Bynum JP, Skinner JS.** Slowing the growth of health care costs — lessons from regional variation. N Engl J Med 2009;360:849-52.

[iv] **American College of Physicians**. Ethics Manual Fifth Edition

[v] **ACP-ASIM Foundation, European Federation of Internal Medicine, and American Board of Internal Medicine.** Medical Professionalism in the New Millennium: A Physician Charter. *Ann of Intern Med*, 2002;136(3):243-46. Accessed on 15 Dec 2009 at http://www.annals.org/content/136/3/243.full.pdf