



## A Growing Disconnect

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By John Ostrich, MD

*Health care consumers are not the same as patients. Consumers go to the store and make reasonable decisions based on cost. Do I really want to have the chateaubriand, or will hamburger do? A patient thinks he or she is sick and wants the best care and every test you can think of, and cost is not a consideration.*

ON JUNE 6, 250 people gathered at the Radisson Hotel to discuss how the healthcare consuming public and providers perceive the role of cost and cost effectiveness in healthcare decision making.

The four hour-long symposium was part of the "Visible Fairness" project of Sacramento Healthcare Decisions, a non-profit group headed by Marjorie Ginsburg that is devoted to encouraging public discussion of healthcare policy and practices.

Questions were raised, scenarios were set.

Mark Smith, president of the California HealthCare (sic) Foundation mused aloud that, when it comes to healthcare, it is all very well to consider the concept of spending money on the greatest good for the greatest number. But the average patient thinks, "If it's my health, then cost is no object." Most physicians really think the same way, he says - "If it's for the good of my patient, then costs should be no object."

The obvious next question was posed: So if price is no object, who pays?

Peter Lee, CEO of the Pacific Business Group On Health, noted that patients are paying less out-of-pocket now than they were 20 years ago Yet they perceive that the healthcare industry (read: managed care) "is doing a lousy job and can't keep costs down in any case."

As part of the Visible Fairness project, 25 public discussion groups comprising 263 participants were held over the past few months at a variety of Sacramento venues. Data were gathered on consumers' knowledge and sentiments about health care in general and how health care dollars should be spent. Some of the meetings were videotaped and all were transcribed.

Vignettes were presented, then discussed. One such vignette was as follows:

Fred is 83 and has recovered nicely from a minor stroke and is taking aspirin as part of his post-CVA regimen. A friend tells him of a new drug, Strokamine, that "works 10 percent better than aspirin" to prevent further strokes.

Fred asks his doctor about it. The doctor admits he knows all about Strokamine, but it costs \$1,500 a year and is only marginally better than aspirin. Fred is upset because he was denied "the best treatment possible" and, anyway, his health insurance would cover the Strokamine cost. So why not prescribe it?

Data collected from the discussion groups revealed that 77 percent thought that "a treatment that works better should be paid for by the health plan, even if it works only slightly better." Almost as many said that "all 'medical advances' should be covered," and 51 percent would require health plans to "cover ALL treatment options."

Are we in big trouble? As the data were presented, it was clear that the public is becoming distrustful of us as a profession as we become more and more beholden to managed care entities for our livelihoods.

The majority of the group participants felt it is not appropriate for physicians to discuss cost effectiveness with patients "because it translates to mean 'you are not worth it.'" Many want to return to the "good old days when doctors made decisions only on the basis of what was best for each individual patient."

"Well, that's fine," said Walter Zelman, president of the California Association of Health Plans. "But that kind of practice is what almost wrecked the whole system in the first place." He added, "Like it or not, managed care has helped reduce costs and kept quality of care high."

Zelman's co-panelist Earl Lui, saw a single-payor system as our salvation. "The doctor will be free again to make decisions based solely on medical need, not financial considerations."

A questionnaire was sent to 999 local docs to try to ascertain how practicing physicians feel about all of this. Over half were returned. Ninety-two percent agreed "there is legitimate need for cost containment" and 95 percent said that "physicians should play a role in helping contain costs." Only 53 percent felt that it is our duty to offer all treatments, regardless of cost, and 81 percent agreed that is appropriate to weigh cost effectiveness when considering various treatment options.

There is, as they say, a "disconnect" developing between our patients' perceptions of health care delivery and our own. One panelist wondered if there might be a significant difference in our approach to the theoretical questions and in our day-to-day diagnostic and therapeutic decision-making when, for example, we are confronted by a frustrated fibromyalgia patient demanding MRI and bone scans and exotic blood tests, or a heavy smoker who wants a yearly chest CT scan "to be sure I'm not developing lung cancer."

I recall once hearing Dr. John Tupper, then Dean of the UC Davis School of Medicine, asked to comment on the "scandalous" fact that healthcare was consuming 13 percent of the Gross Domestic Product. His response: "Maybe that's not high enough!"

And maybe Dr. Tupper was right. Maybe it is time for healthcare to soak up 30 percent of our GDP and for the Pentagon to get 13 or 14 percent. Then Fred can have all the Strokamine he wants, no questions asked.

All of us, healthcare providers and consumers alike, will be free at last. There will be a chicken in every pot and a CABG in every chest.

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