Health Care Reform: What's Wrong With 17.6% GDP?

William J. Bommer, MD, FACC, FACP
President, California Chapter of the American College of Cardiology; University of California, Davis, CA

[Rev Cardiovasc Med. *2013;14(1):66-68 doi: 10.3909/ricm0684*]

The United States has one of the best health care systems in the world. Why do we need to reform it? Health care critics have complained about limited access, higher costs, and variable quality. What is the basis of these complaints?

Access

Full access to health care is not available for many uninsured and uncovered individuals. We have all seen patients in the emergency department who have suffered because they could not obtain or afford insurance coverage for important preventative care or prescriptions. These individuals fell into the gaps and stumbled into the emergency department with expensive, late-stage disease complications. Indeed, this has been a major problem in the past. However, the recently passed Affordable Care Act (ACA) may improve access for these patients in the coming years through more comprehensive insurance and Medicaid coverage.

Cost

US health-care costs have risen quickly over the past decades to 17.6% of the Gross Domestic Product (GDP). The average cost of $8233 per person is twice that of other Organization for Economic Cooperation and Development (OECD) countries.[1] Why does our health care cost more? Those of us with full insurance or government coverage for specialty care and expensive technologies are currently using and enjoying these services. These higher-cost services raise our national health-care expenses. The United States also carries higher administration and legal malpractice costs.

Quality

Life expectancy is lower in the United States than in several other OECD countries. Even with lower health-care costs, people in other OECD countries actually live slightly longer. Despite having higher costs, do we perhaps have lower quality? The media often highlight selected examples of health-care system failure or individual lapses in our standard of care. Statewide risk-adjusted percutaneous coronary intervention (PCI) outcomes have shown that about 5% of California hospitals have worse than expected results.[2] Quality variability could be improved.

What Can We Do to Address These Three Complaints?

Many of the access restrictions should be relieved by the expected implementation of the ACA. However, once patients gain access, we will need to educate health-care providers, patients, and family members about early disease prevention and treatment follow-up. Cardiovascular education is being

targeted with the Million Hearts, Provider Action for Treating Congenital Hearts (PATCH), Imaging in FOCUS, Hospital-to-Home (H2H), Door to Balloon (D2B), Health Outcomes Sciences (HOS) personalizing evidence, and Accreditation for Cardiovascular Excellence (ACE) programs offered by the American College of Cardiology (ACC). Numerous cardiovascular continuing medical education (CME) programs (over 40 in California this year) will be focusing on improving cardiovascular care. We must provide adequate education for all to ensure that effective prevention and follow-up accompany this new access.

There are expensive, high-technology diagnostic and treatment modalities in cardiovascular medicine, and the most cost-effective way to deliver these proven modalities needs to be determined. For acute life-threatening emergencies, early access may be life saving. This is true for acute myocardial infarctions where shorter door to balloon times reduce mortality and morbidity for primary PCIs. Because California is a large state, multiple (141) primary PCI laboratories now exist. Because fewer patients today need emergency cardiovascular (CV) surgery, not every hospital will need on-site CV surgery. Although emergency CV surgery was often needed for early PCI attempts, today it is required in only 0.3% of cases. With fewer revascularizations in general, and even fewer coronary artery bypass graft (CABG) surgeries, many hospitals in the United States and California have low volumes for CV surgery. California had 118 CV surgery hospitals in 2008, but 19 hospitals performed < 1 case/week, and 52 hospitals averaged < 2 cases/week for CABG.[3] Although surgeons can service more than one hospital, the complete CV surgery package of CV perfusionists, anesthesiologists, operating nurses, ICU nurses, technologists, and specialized operating rooms may be very expensive to maintain for only one to two cases per week. Although regulations in California now mandate on-site CV surgery for all PCI laboratories, this could change in the future. Recent reports and clinical trials of PCI with off-site surgery (C-PORT) have shown similar safety and effectiveness compared with hospitals with on-site surgery. In California, the PCI-California Audit Monitored Pilot Off-Site Surgery (PCI-CAMPOS) program has reported similar safety outcomes (death, emergency CABG) between on-site (1.16%) and off-site (1.15%) hospitals for elective PCIs (STEMI-excluded) at six pilot hospitals.[2] If this pilot program is adopted statewide, the need for low-volume CABG surgery programs and their costs may disappear in California.

We need to track costs for new procedures. The California Technology Assessment Forum (CTAF) is reviewing whether each technology demonstrates regulatory approval, proven effectiveness, an improvement in net health outcomes, and benefits comparable to established alternatives outside of investigational settings. Currently, transcatheter aortic valve replacement (TAVR) in patients at high operative risk, PCI as an alternative to CABG for multivessel coronary artery disease in patients with diabetes mellitus, endovascular thrombectomy for acute stroke, intra-aortic balloon pump (IAPB) for cardiogenic shock, and renal ablation for hypertension are under review.

National ACC efforts in cardiology with appropriate use criteria and guidelines have also shown a gradual improvement in appropriateness compliance as recorded in cardiology registries across the country. We may now be doing a better job in containing costs. In fact, the last reported US health care cost/GDP percentage did not rise at all (17.7 to 17.6%).[1]

Can we do a better job of tracking and improving CV quality? Certainly cardiology has been the leader in performing randomized, controlled trials (RCTs), establishing registries, and issuing guidelines. How can we do more?

Guidelines need to be disseminated and available in each office for the clinician and patient. A new digital technology strategy will be the focus of the ACC in 2013.

Registry information needs to be used. Many cardiologists are not aware of their current registry-supplied performance measures. Better awareness will improve data entry accuracy and reliability and may allow us to move to full accountability with public reporting of selected performance measures. Early and effective feedback is an efficient way to improve this quality.

Cardiology leads the pack in large RCTs to evaluate our ever-evolving health care. These trials are very expensive and may not answer all of the questions. An effective postrelease data tracking program might supplement these RCTs in the future.

Our new physicians in Congress may have led US past the fiscal cliff on the bridge to health care reform.[4] Evolving national and state insurance programs coupled with educational programs should improve access to effective cardiovascular disease prevention and treatment. We must do our part by continuing to limit health care cost to just 17.6% of the GDP. At this price, we will continue to have the luxury of shorter waiting lines and more specialists. What if our health care costs 5% more GDP than other countries? Aren't we

worth it? If society wants further cuts they will have to consider reducing administration costs with a simplified, single-payer plan, reducing malpractice costs with tort reform, and reducing drug costs with a nationally negotiated contract. However, these changes may be politically impossible and we will have to remain healthy and happy at 17.6% of the GDP. ■

References

1. Health policies and data: OECD Health Data 2012. Organization for Economic Cooperation and Development Web site. http://www.oecd.org/health/health-systems/oecdhealthdata2012.htm. Accessed January 2, 2013.
2. PCI-CAMPOS Advisory Oversight Committee. PCI California Audit Monitored Pilot with Offsite Surgery. http://www.cdph.ca.gov/programs/LnC/Documents/PCI-CAMPOS-Advisory-Oversight-Committee-01-17-2013.pdf. Published January 17, 2013. Accessed February 2, 2013.
3. Percutaneous Coronary Intervention (PCI) Web site. http://www.pcicalifornia.org/. Accessed February 2, 2013.
4. Bommer WJ. Can docs bridge US over the cliff? *Rev Cardiovasc Med*. 2012;13:e196-e197.