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Money makes the world go around,
The world go around, the world go around,
Money makes the world go around,
It makes the world go around.

—From *Cabaret* (Fred Ebb and John Kander)

“It’s so difficult caring for patients these days! Rules and guidelines, financial and managerial barriers drive doctors crazy.”

“Steve, I keep reading about presidential campaign promises in your newspapers. What do you think will actually happen to the US health care system with a new President?”

“Mike, I keep reading that the National Health Service (NHS) is changing too—is it really? How long are your waiting lists?”

“How can physicians influence what’s happening in our countries? Do we actually know what we want?”

We were seeing patients together.

“Because we still have 45 million uninsured in the United States, there are people who say that health insurance for everyone needs to be our first priority.”

“I would certainly agree with that, Steve! We see universal coverage as a responsibility of society to all its citizens; the marketplace has a role, sure, and you could devise a system that places the market in control. Obviously, there are health care systems other than the NHS model that could be considered. And after all, no other country has followed the United Kingdom in its tax-based, universal, cradle-to-grave, everything covered, open to all, free at the point of care, system—60 years old this year. There must be a message there. Perhaps this election will generate the debate that needs to take place in the United States.”

“You’re right—there’s no groundswell in the United States to emulate the NHS! But universal health insurance won’t solve the issue of runaway health care costs any more than your tax-based system has. When I entered medical school in 1964, the Medicare/Medicaid programs were on the drawing board and total medical expenditures were one-seventh of the cost today. Economists estimate that Americans will spend over \$11,000 yearly for medical care in just 6 years’ time. It’s sobering to realize that Americans spend a greater percent of disposable income today on medical care than on housing, food, or clothing.”

Money and medicine

A problem that won’t go away

“And the United States spends more per person on health care than any European country. Yet the statistics don’t show remarkably better outcomes for most conditions. You Americans are an impatient bunch. You want the best medical care, no matter what it costs, and you want it *now*.”

“Mike, I know that England’s NHS tightly controls medical expenditure. But, as we see it in the United States, the result has been unacceptable waiting lists, failure of investment in technology, and lack of availability of new treatments. We see it as rationing of care. There are also differences in health outcomes between different parts of the United Kingdom. That shouldn’t occur in a universal healthcare system, should it?”

“All of your criticisms have justification, Steve; in general, the British have been less demanding of their health care provider—the NHS. And yes, they have become inured to waiting, sometimes for long periods, for elective medical care. That issue has finally surfaced in widespread discontent, with recognition that the NHS could and should do better, and that this requires increased funding. For too many years the number of consultants (i.e., specialists) was kept to a minimum by financial constraints, but things are changing rapidly. Our patients are becoming better informed and have increasingly greater expectations. Consequently, the NHS is facilitating easier and more rapid access to medical help and is providing better facilities.”

“One thing we should be clear about with regard to modern medicine is that greater longevity, especially in North America and in Western Europe, is not really a consequence of better medical care. Factors such as diet, exercise, stopping smoking, moderate alcohol use, and childhood immunizations have made a difference in the West in general, although the former Eastern bloc countries are lagging.”

We returned to our concerns about cost containment.

“But the reason we’re having this discussion, Mike, is because not everything we spend on medical care is a good return on investment. I’m not an economist, but I recognize that no matter how our respective health care systems are structured and financed, physicians have to do much more to identify the

value of specific medical services. If doctors don't play that role, we'll simply go broke."

"In Britain, NHS health economists and managers have taken charge of that issue, to the great concern of physicians. But, as you say, economists don't take care of patients. Doctors are pivotal in deciding what medical care offers the greatest value. Although we practice medicine in different financial systems, both of us struggle for answers, and the decisions we make affect the medical systems enormously."

"Would the patient we just saw with diabetes and chronic renal failure be referred to a British neurologist for evaluation of a neuropathy?"

"Very unlikely; we both know that the likely cause of the neuropathy is his diabetes, so why a neurology consult? Surely his nephrologist can handle that issue most of the time."

"His weight loss could be from an occult malignancy, a vitamin deficiency, or autoimmune disease, all conditions we can help."

"True, but it's very expensive to recommend a whole battery of tests looking for unlikely causes for his symptoms when the likely cause is so apparent."

"Would this patient even receive dialysis in England?"

"Yes. In general, the decision is the patient's to make, provided there are no adverse factors."

"And what about the myasthenia gravis patient we saw earlier who was refractory to conventional immunosuppressive treatments. Could she receive rituximab in England? As you know, evidence of its benefit is just emerging and this bioengineered medication is very expensive. Even some American insurers deny payment saying that there's not enough evidence of its therapeutic advantage."

"Well, what you are proposing is essentially an experiment, since the supportive data are anecdotal. However, there has been widespread concern in the United Kingdom, among physicians, the media, and not least among patients, that the NHS was denying patients advances in medical technology on grounds of cost. This led to the establishment of the National Institute for Clinical Excellence (NICE) in 1999. Basically, NICE appraises new technologies and calculates their cost-effectiveness in relation to their therapeutic benefits, recommending whether the treatment should be approved for use in the NHS. Hospitals and practices are required to adhere to these guidelines, although exceptions are made for individual cases on occasion."

"Our approach to coverage decisions in the United States isn't centralized at all. Doctors spend enormous amounts of time seeking preapproval from individual insurers and urging that a particular new medication be included in a formulary. While one

insurer might agree with a physician's recommendations, another might decline payment for the same approach."

"We've tried to standardize comparisons between therapies. NICE calculates what economists refer to as a health utility—a quality-adjusted life-year. Essentially it is an estimate of the cost of the additional quality of life provided for a year for any therapy. Although this approach theoretically helps us determine which technologies provide the greatest value, there certainly are limitations. For one thing, the analyses take time and, of course, not everyone agrees with the methodology. Furthermore, we all know that much of what physicians prescribe is of unproven benefit; some even potentially harmful."

"Mike, study after study shows wide regional variations in care in the United States."

"That's an international problem."

"In the United States, payers, insurers, regulators, and certifying agencies are all asking physicians to collect performance data in hope that they can drive more standardized care. Unfortunately, no one has quite figured out how to harmonize these efforts since it's hard to identify data that truly reflect high quality care. Not surprisingly, doctors distrust such attempts, which limit physician autonomy, exclude patient choice, and appear to focus more on reducing cost than on optimizing treatment. And it costs money and time to collect this information. So, in the name of safety and quality, when doctors already think their reimbursements are inadequate, we ask them to collect data so they can then be held accountable for unproven medical practice measures. It feels like another bureaucratic mandate that doctors will try to circumvent."

"In Britain, the underlying philosophy is to provide the best care for the greatest number of the population, the principle of equity, so cost-effectiveness is a major priority in the healthcare system. But like you we also have a long way to go in standardizing health care. We refer disparagingly to regional differences in treatment as 'post code prescribing.' Physicians constantly look for ways to get around the system."

"If we adopted your NHS centralized budgeting process in the United States, I can envision what would happen if a particular treatment was denied. There are already newspaper and television stories about people who die because of insurance denials. If we nationalized coverage decisions, our physicians would join their patients in protest. There would be Congressional hearings, and politicians would have no choice but to intervene."

"Believe me, that is exactly what happens in Britain, but at least the debate is then a public process. We both know that to get elected, politicians don't

like to emphasize the dreaded word 'rationing.' Our British Health Secretary said in an interview that he was trying to make the NHS 'less monopolistic and more a patient-driven organization.' But he also is responsible for a rapidly growing NHS budget."

"Mike, it feels like both our countries are racing the clock to identify standards to improve the quality and value of our health care systems. How do we convince physicians that they need to be at the forefront of cost reduction strategies when they already feel overworked and underpaid?"

"If I've learned anything by working in the NHS, it is that money can drive change. American doctors are obviously a critical resource to increase efficiency and reduce waste. If doctors don't get involved or, worse yet, work to undermine reforms, others with differing perspectives and experience will make cost cutting decisions for them. I recently read that most Western nations waste 25% of their food purchases. But with encroaching food and energy shortages, changes in behavior can be expected to follow. Should not the same thinking be applied to medical care?"

"It's easy to say that we should get rid of health benefits that are not cost-effective, Mike, but we both know that eliminating waste is a painfully slow process that requires patient and physician education, and a lot of debate and analysis. Many of the reasons for rising health care costs are beyond any doctor's immediate control. Although doctors shouldn't be held responsible for consumer demand, poor health habits, and the enormous administrative costs associated with medical care, they have an essential educative role."

"We can agree on ways to avoid overinvestigation and overtreatment and help objectively to identify the benefits and risks of new technologies. Either we help identify palatable and effective solutions, or we become part of the problem. Things have to change, or we'll deplete our nations' funds."

Money makes the world go around. Now that's something Americans certainly understand. People should have access to the best treatments, and they're more likely to get it if doctors have a say in the type and level of their care.

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Steven P. Ringel and Michael Swash

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