

Editorial

THE HEALTH OF OUR HEALTH CARE SYSTEM

By Richard H. Savel, MD, and Cindy L. Munro, PhD, RN, ANP



As our country struggles to figure out whether we feel that having access to health care is a “privilege” or a “right,”^{1,2} we here at *AJCC* wish to share with you some of our thoughts regarding the current status of our health care system and how “healthy” it really is. Though we all take great pride in our country and believe our health care system to be the greatest in the world, the data unfortunately point in a different direction: some components of our vaunted health care system are truly broken and in desperate need of repair. In certain rankings, our country makes the top of the list. Unfortunately, those lists are of cost per patient; of equal concern, those greater costs do not translate into clear-cut benefits for patients, as we routinely come up near the bottom of international lists of quality of care and access to care.^{3,4}

In addition to having a health care system with high costs and limited access, we are simultaneously dealing with a fundamental crisis of drug shortages, specifically in the intensive care unit (ICU).^{5,6} We are not referring to “fancy” pharmaceuticals such as complex synthesized monoclonal antibodies or other such designer drugs; rather we are referring to what are considered “basic” tools of our trade such as epinephrine, norepinephrine,

vasopressin, dextrose, certain antibiotics, and—nearly defying comprehension—sodium chloride and sodium bicarbonate. Given the fact that the United States has the highest gross domestic product at \$19.4 trillion in 2017,⁷ some of these facts should cause great concern.

One of the root causes of these runaway costs without concomitant increases in obviously measurable quality occurs during training of health care providers. Not only is the concept of “value” not routinely taught in nursing or medical school, but some authors point out that, in their minds, it is unethical to incorporate and integrate the teaching of “high-value” health care into routine training. Specifically, Decamp and Riggs, in a “Viewpoint” article published recently in *JAMA*,⁸ describe how they disagree with the trend toward attempting to assimilate the concept of value into standard health care education.^{9,10} Fundamentally, they state that if a clinician is cognizant of the fact that we are ALL practicing in a world where resources are limited, then we are potentially jeopardizing our professional identity with regard to the primacy of commitment to patient welfare. We found this outlook startling and somewhat confusing for multiple reasons.

One can easily find examples in which teaching about the concept of providing health care as part of an integrated systems-based approach is not only

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crucial, but mandated. As an example, such an approach is part of the 6 core competencies of the Accreditation Council for Graduate Medical Education (ACGME) to teach systems-based practice as part of a residency program, as well as the ACGME milestones.¹¹ In addition, we also had some concerns with the philosophical approach that somehow if clinicians integrate cost, value, and other systems-based issues into their routine care, then they are unable to provide as high a quality of nursing or medical care as one of their colleagues who practices in isolation from value-based ideas. The implication here is that practicing nursing or medicine without taking cost or value into account leads to higher quality outcomes: unfortunately, as we described in the first paragraph, the data do not support that.

Any discussion of the economics of health care often leads to the topic of “rationing.”¹²⁻¹⁴ Many of us are not comfortable with that term, but as the national debate on health care rages on, this issue will continue to arise. When a health care provider is working with any individual patient, the focus is on providing the highest-quality care for that patient without regard to costs or to resources used. Although this does sound like a high-quality “prime directive” from which to start, the problem is that—in our country—this approach has led to skyrocketing costs without concomitant increases in quality, either at the individual or population level.

What are some potential solutions to this incredibly complex and highly controversial topic? Some would argue that it is not the role of government to provide health care to all members of the population, regardless of their ability to pay. Their discussion then would logically continue that, for those who can afford it, patients will be able to receive their health care and work out with their clinicians what the “best” care plan is, regardless of the resources involved. People who can afford health care receive it,

and the health care plan is one between a patient and his or her clinician: period, end of story. Not only are there obvious moral problems with this particular stand, but even as a purely economic argument, it makes little sense to allow many in a large nation to have limited access to affordable health care.

Unfortunately, we do not believe that the idealized aforementioned description can or should become the status quo. We would make 4 recommendations for moving forward with improving the health care access/quality/spending crisis in our country:

1. All members of society should have access to high-quality, affordable health care. Although we are well aware that this statement is highly controversial, we see this as a crucial first step to obtain meaningful progress in this area. As anyone who understands the basic concept of insurance will explain, until everyone is part of the system, the system is not fair and will not function well.

2. The concept of “high-value” health care should be taught as early as possible in clinician education. We not only strongly disagree that there are potential ethical conflicts created by teaching that the resources in health care are limited but feel that it is potentially unethical to NOT teach about the health care system as a whole, as it truly exists. The rift between the reality of “health care as an industry” and the solitary country doctor caring for his or her patient remains significant.

3. Government must figure out a way to work on limiting resources in an equitable fashion when these resources potentially may have little or no benefit to patients. This concept of rationing has remained an incredibly unpopular topic, as no one wishes to face the stark reality that resources are not limitless, and that no one clinician will work to limit resources when it comes to his or her patient. The inevitable outcome is the health care spending/cost crisis we are currently experiencing. This topic is particularly germane to critical care.¹⁵

4. Finally, in terms of drug shortages and escalating pharmaceutical costs: federal and state government should work with leaders in the health care industry to find the root cause of shortages of crucial drugs, restore their supply, regulate their costs, and prevent future drug shortages. Accomplishing this may require increases in resources dedicated to current agencies, as well as the potential creation of new ones, but we can think of no better indication

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“ We can think of no better indication for government oversight than to ensure that critical drugs are always available, and for a reasonable cost. ”

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The fundamental manner in which health care is paid for in this country is at a crossroads. Intense philosophical debates are transpiring on a daily basis to determine what our new health care delivery system will look like. Clinician leadership courses emphasize the crucial nature of understanding concepts such as finance, operations management, and institutional strategy—business areas not routinely covered in clinical educational curricula. The harsh reality is—whether we like it or not—the health care industry is, in fact, an industry. We would proffer that the sooner clinicians are introduced to these important “nursing/nonmedical” areas of study—and made aware that health care must simultaneously be of high quality while also being efficient and taking limited resources into account—the more likely we will be to have a “seat at the table” when important decisions are being made to shape the future of our health care system. If nurse and physician education does not contain an introduction to these crucial areas, many of us will be left to manage a situation in which we are unable to contribute to the solution because we were never versed in the vocabulary of the problem in the first place.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

FINANCIAL DISCLOSURES

None reported.

REFERENCES

1. Bauchner H. Health care in the United States: a right or a privilege. *JAMA*. 2017;317(1):29.

2. Lenchus JD. The right to health care. *JAMA*. 2017;317(13):1377-1378.
3. U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries. The Commonwealth Fund website. <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>. Published October 8, 2015. Accessed August 1, 2017.
4. Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally. The Commonwealth Fund website. <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>. Published June 16, 2014. Accessed August 1, 2017.
5. Donohue JM, Angus DC. National shortages of generic sterile injectable drugs: norepinephrine as a case study of potential harm. *JAMA*. 2017;317(14):1415-1417.
6. Fox ER, Sweet BV, Jensen V. Drug shortages: a complex health care crisis. *Mayo Clin Proc*. 2014;89(3):361-373.
7. Bureau of Economic Analysis, US Dept of Commerce. Gross Domestic Product: Fourth Quarter and Annual 2017. https://www.bea.gov/newsreleases/national/gdp/2018/pdf/gdp4q17_3rd.pdf. Accessed May 3, 2018.
8. DeCamp M, Riggs KR. Navigating ethical tensions in high-value care education. *JAMA*. 2016;316(21):2189-2190.
9. Korenstein D. Charting the route to high-value care: the role of medical education. *JAMA*. 2015;314(22):2359-2361.
10. Stammen LA, Stalmeijer RE, Paternotte E, et al. Training physicians to provide high-value, cost-conscious care: a systematic review. *JAMA*. 2015;314(22):2384-2400.
11. Chapman DM, Hayden S, Sanders AB, et al. Integrating the Accreditation Council for Graduate Medical Education core competencies into the model of the clinical practice of emergency medicine. *Acad Emerg Med*. 2004;11(6):674-685.
12. Evans TW, Nava S, Mata GV, et al. Critical care rationing: international comparisons. *Chest*. 2011;140(6):1618-1624.
13. Prin M, Wunsch H. International comparisons of intensive care: informing outcomes and improving standards. *Curr Opin Crit Care*. 2012;18(6):700-706.
14. Scheunemann LP, White DB. The ethics and reality of rationing in medicine. *Chest*. 2011;140(6):1625-1632.
15. Truog RD, Brock DW, Cook DJ, et al. Rationing in the intensive care unit. *Crit Care Med*. 2006;34(4):958-63; quiz 971.

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