A Sense of Priorities for the Healthcare Commons

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Abstract: Limited resources make it impossible to deliver all healthcare services to all people. Therefore, it is vital for the nation to adopt rational methods for setting priorities. The work of the National Commission on Prevention Priorities takes such an approach in ranking the relative importance of effective preventive services, and it carries important implications for policymakers, clinicians, and patients. The crisis facing health care requires society to function as a community to use limited resources in ways that maximize the public good.
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Health care, like other public goods and personal services, does not operate in an environment of unlimited resources. Quite the contrary. The rising costs of health care are straining the capacities of the economy of the United States. Insurers are raising premiums, businesses are passing costs onto employees, and the expansion of the Medicare program to cover rising costs is straining the federal budget.[1] The ability of our country to compete in a global economy is in jeopardy, according to some experts,[2] because of the alarming costs of health care.

But money is not the only limited resource. For clinicians and patients, time is an equally precious commodity. In the primary care setting, for example, there is too much to be done—for acute problems, chronic illness management, and the prevention of disease—in the brief period of time available in routine office visits. Yarnall et al.[3] estimate that it would take 7.8 hours per day for a primary care clinician to deliver the preventive services recommended by the U.S. Preventive Services Task Force.

Under conditions of limited time and resources, the issue is not whether prioritization occurs—some things simply get done while others do not—but how it occurs. In most settings, the process, whether it is called rationing or prioritizing, is neither systematic nor rational.[4,5] Some services come off the table because of limited access to care or insurance coverage.[6] Some are eliminated because of inadequate time, simple oversight, or competing demands.[7–10] Many are prioritized because the clinician or patient considers them important, while services of potentially greater effectiveness are overlooked.[11]

The consequences of these misplaced priorities are hardly esoteric. Diseases develop, extant illnesses worsen, and people die prematurely when health care fails to deliver the most effective services.[12,13] For example, the primary prevention of disease would save more lives than treating diseases after symptoms develop, but the vast resources of the healthcare system are spent largely on the latter.[14] Failure to realign priorities sacrifices both lives and resources. Health could be markedly improved, with far less expenditure, if our healthcare system prioritized services based on their effectiveness and value (the cost of services per unit of health improvement).

Perhaps because it is a country that prioritizes poorly, per capita spending on health care in the United States is more than double the median for industrialized countries,[15] and yet, on many indices, its health outcomes are below average.[15–17] Perhaps because these resources are expended without a clear sense of priorities, the delivery system fosters the troubling coexistence of overuse—an abundance of services that are ineffective or harmful and often costly—while basic services are unavailable to so many.[18] The healthcare system that spends billions of dollars on unnecessary services[19] delivers only half of recommended services to the general population[11] and does even less for racial and ethnic minorities and the disadvantaged.[20]

A new approach to health care that gives priority to the services that help patients the most is urgently needed, but the first step is to determine how to set such priorities. The recommendations of the National Commission on Prevention Priorities (NCPP)[21] could not come at a better time. The NCPP presents an approach to setting priorities based on health benefits and cost-effectiveness that is applicable not only to

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preventive services but, with some modification, to health care generally.

The NCPP is hardly the first effort to prioritize healthcare services based on effectiveness and cost effectiveness. It carries the legacy of its historical antecedents, including the Oregon Medicaid reform plan[22] and the New Zealand priority criteria project,[23] which confronted challenges of methodology, implementation, politics, and ethics to set priorities.[24] The Oregon effort tried to incorporate community views and cost–benefit ratios into its rankings, but the challenges of collating public input and inadequate cost information led to controversial rankings, such as giving tooth capping higher priority than appendectomies. The rankings were later modified by a commission but remained subject to criticisms that apply still to today's efforts, such as the failure to account for the heterogeneity of populations and to examine the effect of marginal interventions associated with services.[4] As Hadorn[22] concluded in 1991, "[a]bsent a gold standard of validity, there can be no 'right' way to set healthcare priorities, nor any single 'correct' list or set of guidelines."

The NCPP faced similar challenges in deriving a scheme to prioritize preventive services. The article in this issue by Maciosek et al.,[21] informed by their previous effort,[25,26] discusses a variety of factors that could influence the precision of its rankings, such as which preventive services were examined and how they were defined; inadequate evidence about the efficacy and costs of some services, especially in subpopulations; the metric used for comparing health benefit (quality-adjusted life years); assumptions about patient adherence and the value of patients' time; and the choice not to measure marginal effectiveness. The authors note that the rankings do not reflect the value that patients assign to services, reimbursement, or disparities in care.

We learn from these methodologic considerations that the science of prioritization requires further leavening before it can be applied as a tool of precision. Given the wide confidence intervals that surround some values used in NCPP calculations, whether a service is ranked fifth or sixth in importance is less worthy of scrutiny than the broad-scale distinctions among the five tiers of services (see Table 1 of Maciosek et al.[21]). The key take-home message of the NCPP is that our society should not continue its profligate over-investment in services in the lowest tiers at the expense of under-used high-tier services. The take-home message has other implications for policymakers, clinicians, and patients.

Policymakers should consider whether the programs for which they are responsible are providing upper-tier preventive services. Managers of health systems, leaders of health plans, employers and benefits managers, brokers who advocate coverage packages, and government officials responsible for Medicare and Medicaid should examine whether their policies, products, and supporting infrastructure facilitate, or hinder, the delivery of highly ranked preventive services. For example, smoking-cessation counseling, one of three services to receive a "perfect" NCPP score of 10, is encumbered in many settings by inadequate information systems to systematically identify patients who smoke, poor access to personnel with the time and skills to offer effective counseling, undeveloped referral mechanisms to link patients with outside resources (e.g., telephone quit lines), and gaps in insurance coverage for counseling or adjunctive medication.[27,28]

Similar barriers (and new opportunities) exist for other top-tier services. Particular attention should be paid to the services with low utilization rates (see Table 2 in Maciosek et al.[21]). According to the NCPP report, less than 50% of eligible patients are receiving important services (e.g., counseling regarding aspirin, screening for colorectal cancer, screening for vision impairment, pneumococcal vaccination of seniors, and screening for problem drinking).[21] Policymakers should closely examine infrastructural impediments to delivery.

With supportive systems, many of these services can be delivered at higher rates and in a more personalized context within an enhanced primary care infrastructure.[29] Although the report focuses on **clinical** preventive services, effective delivery of these services often requires a partnership between feasible practice interventions and effective community and public health solutions.[30] The greatest advances in prioritized delivery may be possible by supporting collaboration between clinicians and community groups in systems that integrate the services and the unique strengths that each brings to preventive care.[31,32] Managers of health systems have a vital role to play in assembling and financing the infrastructure for this integrated systems approach.

Policymakers should not use the rankings "off the shelf" without considering the characteristics of the population they serve. The preventive services that belong in the upper tier may differ, for example, when programs serve predominately seniors, Native Americans, or patients enrolled in a specific health plan (e.g., Medicaid). An electronic tool to be developed by the NCPP may help policymakers tailor priorities to local population characteristics. Finally, policymakers should recognize that giving priority to a preventive service is, quite often, less about investments to enhance efficacy (e.g., purchasing newer screening technology) than about improving the fidelity with which it is delivered. Other work has shown that investments in systems to ensure that patients receive recommended services can do more to improve health outcomes than making the services more effective.[33]

Among clinicians, the NCPP rankings have greatest relevance in the primary care setting. It is in primary care where most outpatient encounters occur and where the breadth of conditions covered by the NCPP is encountered in daily practice and must be incorpo-

rated into the larger tableau of patients' needs.[34,35] The rankings provide a rational backdrop for the daily primary care task of matching multiple opportunities with patients needs and values.[8,33] The rankings pertain also to specialists in helping to clarify the relative importance of preventive services that fall within their domain.[36] Specialists, who are sometimes more likely than primary care clinicians to see patients with chronic or recurring conditions, might be persuaded by the NCPP to include preventive services that are ranked more highly than those normally within their purview.

Both primary care clinicians and specialists should use the NCPP report as a reference point for exploring whether their office systems and patient care procedures accommodate the delivery of first-tier preventive services. They should think about how to internalize the priorities identified by the NCPP. For example, when advising the 52-year-old female patient who requests a bone scan, a clinician with a sense of priorities and informed by the NCPP, will note the cigarette package in her purse and recognize that it poses a far more urgent health priority than does osteoporosis screening. A clinician with a sense of priorities can persuade the 25-year-old obese man who wants a blood test for diabetes that physical activity and weight management are far more likely to prevent the complications he dreads.

For many conditions, the clinically preventable burden[21]—the metric used by the NCPP to rank services—is influenced by a patient's risk of disease. The astute clinician recognizes the importance of customizing priorities based on individual risk profile and personal preferences. Moreover, the highest priorities in the long view may not be the priorities of the moment, when the amount of time available, opportunities for "teachable moments,"[37] and other contextual circumstances may elevate the importance of one preventive service over another.

The NCPP rankings have obvious salience to healthcare consumers (patients), perhaps more than they realize. The public consumes a steady diet of crafted messages about the importance of healthcare services that are driven less by science and effectiveness than by the intensity of advocacy.[38,39] Screening tests that are given visibility by celebrities, politicians, advertising, or news reports are often less beneficial to the public than other services neglected by the spotlight.[40] Some heavily promoted tests (e.g., electron-beam computerized tomography scanning for coronary artery calcification) have received "D" recommendations from the U.S. Preventive Services Task Force, indicating that research has shown them to be ineffective or harmful.[41] Americans' fascination with technology leads many to gravitate to whole-body helical computed tomography screening and other technologic innovations, irrespective of their effectiveness.[42] The NCPP report, repackaged in an effective social marketing campaign, could help the public understand that first-tier services are far more likely to enhance their health than the latest test featured on the evening news.

Not to mislead patients, it is important for lay messaging to emphasize that individual priorities differ based on personal history. Two of the three most highly ranked services—smoking-cessation counseling and childhood immunizations—are not pertinent to a nonsmoking adult, in whom a family history of early-onset colorectal cancer may eclipse other priorities. In the ideal transformed healthcare system, patients would receive individualized rankings based on their personal risk profile. Given the pace of advances in information technology, it should soon be possible for electronic health record systems to produce such personalized rankings by applying individual risk factors to effectiveness data, refreshed regularly by updated evidence syntheses. The first glimpses of such a system are already in view with Archimedes,[43] a sophisticated model that can individualize the projected outcomes of treatments for diabetes. Whether such programs are incorporated into decision support tools used by clinicians and patients will depend not only on technologic innovation but also on buy-in from industry that an attractive market exists for such functions.

Although the priority for specific services may differ at the individual level, the societal benefit does not. And when society benefits, so do the members of that society. For example, reducing overuse of services that are of limited or no effectiveness frees up resources that are necessary to offer more effective services—something that benefits all members of society. Nonsmoking adults may not benefit directly when clinicians counsel smokers to quit, but they benefit indirectly from the cleaner air and the healthier youths (who eventually may be their caretakers).

Moreover, society benefits from processes, such as these, that help its members see their commonality. In critiquing the NCPP report, it is easy for advocates of specific preventive services to adopt parochial stances in defending turf and rejecting the rationale for more highly ranked preventive services. Ours is a time in which the fidelity of the healthcare system may be unraveling, potentially crumbling in slow motion at the feet of the patients it exists to serve.[44] It is a time of crisis that requires coming together as a community,[45] an ethos that many world observers find lacking in the United States. The villagers of long ago discovered the wisdom of prudent husbandry of the commons by placing the public good over self-interest. A sense of community and commonality would help healthcare leaders deal responsibly with the belt that is tightening around available resources. A prioritized look at resources for prevention could lead to a similar prioritizing of other healthcare expenditures, and eventually to the notion that spending more outside of health care (e.g., on education and other social determinants of health) could do more to enhance health outcomes for the population.[46,47]

The health of the public and the economy are at stake if society turns away and misses its chance to adopt rational healthcare priorities. Leadership is needed to advance the methods, recommendations, and values championed by the NCPP. Individuals—whether they wear hats as citizens, patients, payers, clinicians, or policymakers—must be honest with themselves and others. Society cannot have everything, nor can it escape trade-offs. These trade-offs are better dealt with as carefully considered priorities, rather than being "swept under the rug," and through communal dialogue and civil discourse, rather than through parochial maneuvers for self-advantage. It is a time when reason and compassion—both head and heart—call on us to do what is best for all.

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