

A Q&A WITH ERIC TOPOL, MD

What Accounts for the High Cost of Care? It's the People.

Interview by Allison Inserro

To mark the 25th anniversary of The American Journal of Managed Care® (AJMC®), each issue in 2020 will include a special feature: an interview with a thought leader in the world of healthcare and medicine. Because the January issue is our annual health information technology issue, we turned to Eric Topol, MD, the director and founder of the Scripps Research Translational Institute and executive vice president, Gary & Mary West Endowed Chair of Innovative Medicine, and professor of molecular medicine at Scripps Research. He is the author of 3 books about how digital health and artificial intelligence (AI) are changing the future of healthcare.

AJMC®: When AJMC® launched in 1995, it was shortly after the Clinton healthcare plan had failed in Congress and 15 years before the Affordable Care Act was enacted. Right now, more Americans have health insurance, but struggles with price, cost, and access remain. What will it take for the United States to bring down the cost of care and widen access?

ERIC TOPOL: Well, there are many strategies that are required; there's not a simple solution. The price, the cost of care—it's preposterous in the United States. That is in part [due to] the lack of negotiation of the government and tolerance for skyrocketing prices, not just of drugs, but [also] of hospitals and every aspect of medical care in this country. It's whatever the market will bear; there are very significant lobbying forces that need to be reckoned with. So, the cost of care, I do think, is completely out of control, having spent quite a bit of time in the review of the National Health Service in the United Kingdom, where the cost per individual citizen is almost one-third of the US [cost] with outcomes that are superior. We have a ways to go to get this on track.

AJMC®: JAMA published an update about waste and healthcare spending that estimated a new range of waste in the healthcare system going up to \$935 billion.¹ If we took certain actions to cut that waste, we could save as much as \$282 billion. This may seem like a chicken-and-egg question, but how can we afford some of those technological innovations and discoveries you discuss in your books while that level of waste still exists? At the same time, there's an opportunity for those innovations, like AI or machine learning, to get rid of that waste. Can both happen at the same time?

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TOPOL: I know, I'm familiar. There were many different commentaries associated with the JAMA paper, and they claimed a fourth of healthcare dollars [spent] in the United States are waste. Of course, Berwick and my analysis and others would suggest it's much more than a fourth: It's more like a third. It's a multipronged thing. Technology is just 1 part of that. We still reward, basically, a fee-for-service mentality. We reward unnecessary procedures and testing and medications and everything. Until we stop that, we're not going to get to the root of the problem. But there are technical ways to do that, as well. There are ways to have decision support, to monitor things in real time. There are all sorts of ways that technology can be a supplemental way of getting our arms around that problem, but I do think hundreds of billions of dollars a year in the United States could be saved by eliminating the unnecessary, inappropriate, and wasteful day-to-day practices.

AJMC®: Would doing that be a question of will, political will, or some other kind of organizational issue?

TOPOL: Well, it's a combination of will, with all the pushback.... We haven't done anything to get out of that mode to get people out

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of hospitals to have them monitored in their own home. That could save not just the waste, but that could cut into the actual, what's considered nonwaste today....A lot has been focused on drug pricing, and it's obviously appropriate to zoom in on that, but it's much, much bigger than pharma. It's hospitals and all the associated labor.

The other thing that's as fundamental is that we keep adding more people—human capital, labor—to the labor force, which is accounting for the absurd cost of care. And there are ways to do that without people. In fact, cutting the job force, and we aren't doing that...that requires not just will, that requires modernization and not relying on people who [are] very expensive. This country is so into getting the employment rate up or unemployment down and not thinking about ways that we can replace lots of jobs or reduce the human capital requirements.

AJMC®: Are you talking about direct care staff or administrative staff or both?

TOPOL: Well, administrative staff. We have an absurd ratio of administrative staff relative to patient care, frontline people—it's completely absurd. By the end of this year [2019], it's projected we will have 100,000 human scribes, which is also absurd. We should be using AI and natural language processing to do that instead of human scribes. There are literally hundreds of thousands of jobs in this country that could be replaced with technology or at least reduced in terms of the number of full-time employees, because much of their effort could be done via machines and algorithms. So we're not doing that either.

AJMC®: Are you talking about remote monitoring technology, or technology at the bedside?

TOPOL: No, I'm talking about getting rid of keyboards, getting rid of human scribes, getting rid of people who do coding, who do chart reviews, who do all the back-office operations. Basically, a very large proportion of administrators could be reduced without any reduction in outcomes for patients but with reduction in cost. It's every level, not just the remote monitoring....Lots of administrative operational functions could be cut drastically, without any

reduction in outcomes—in fact, [it would] probably [come] with improvement but certainly with reduction of costs.

AJMC®: Would that be an improvement because you wouldn't have human error when people are cutting and pasting and making assumptions?

TOPOL: Right, exactly. We are an error-laden healthcare mess, with over 12 million serious diagnostic errors a year—they have to get better. And that's also driving up the cost of care, [not to mention] poor outcomes. That too has to be addressed.

AJMC®: Speaking of negotiation, can health improvements be brought about by this technology, and by the deep learning that you've always talked about, if income inequality still exists or keeps growing? Where does that come into play?

TOPOL: I think with digital technologies and software algorithms, it would be cheaper to give that to the indigent than to have them come in [for] 1 emergency [department] visit or 1 night in the hospital. Years of smartphone, internet, broadband, apps, sensors—you name it—would be far more parsimonious with expecting better outcomes than the way it costs today in our US healthcare system. We haven't gotten at all progressive about trying to reduce the digital divide and the inequities by using technology because it's so much cheaper, and we're not taking advantage of Moore's law.²... We don't even exploit that to reduce the cost of care and also reduce health inequities.

AJMC®: Do you want to say anything else about the future of healthcare?

TOPOL: [Laughs] No, I think I've said enough. ■

REFERENCES

1. Shrank WS, Rogstad TL, Parekh N. Waste in the US health care system: estimated costs and potential for savings. *JAMA*. 2019;322(15):1501-1509. doi: 10.1001/jama.2019.13978.
2. Alvarnas J. From the editor-in-chief: oncology in the time of "Moore's law." *Am J Manag Care*. 2019;25[5 Spec No.]:SP140.

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