The Overtreated American

One of our biggest health-care problems is that there's just too much health care. Cutting down on the excess could save enough to cover everyone who is now uninsured

BY SHANNON BROWNLEE

Americans enjoy the most sophisticated medical care that money can buy—and one of the most vexing health-care-delivery systems. We spend about $1.2 trillion each year, two to four times per capita what other developed nations spend, yet we can't find a way to provide health insurance for 41 million citizens. After a brief respite in the 1990s when HMOs held down expenses by squeezing profits from doctors and hospitals, medical costs are once again soaring by 10 to 12 percent a year. Yet reforms proposed by Congress and the White House are only nibbling around the edges of the problem.

Such political timidity is understandable, given the experience of would-be reformers of the past. Any attempt to expand coverage for the uninsured while holding down costs inevitably raises fear in the minds of voters that the only way to accomplish these seemingly opposing goals is by restricting access to expensive, life-saving medical treatment. Sure, we feel bad about the 18,000 or so of our fellow citizens who die prematurely each year because they lack health insurance, and about the seniors who are forced to choose between buying food and buying medicine. But Americans want nothing to do with a system like England's, which, for example, is reluctant to provide dialysis to the elderly, and most of us who are now covered by either Medicare or private insurance have little stomach for health-care reform that contains even a whiff of rationing.

Behind this fear lies an implicit assumption that more health care means better health. But what if that assumption is wrong? In fact, what if more medicine can sometimes be bad not just for our pocketbooks but also for our health?

An increasing body of evidence points to precisely that conclusion. "There is a certain level of care that helps you live as long and as well as possible," says John Wennberg, the director of the Center for Evaluative Clinical Sciences at Dartmouth Medical School. "Then there's excess care, which not only doesn't help you live longer but may shorten your life or make it worse. Many Americans are getting excess care." According to the center, 20 to 30 percent of health-care spending goes for procedures, office visits, drugs, hospitalization, and treatments that do absolutely nothing to improve the quality or increase the length of our lives. At the same time, the type of treatment that offers clear benefits is not reaching many Americans, even those who are insured.

That's a sobering thought, but it opens the possibility of a new way to look at the conundrum of health-care reform. Lawmakers, insurers, and the health-care industry might be able to save money if they were to concentrate on improving the quality of medicine rather than on controlling costs. Better health care will of course mean more medicine for some Americans, particularly the uninsured; but for many of us it will mean less medicine.

Support for this idea can be found in *The Dartmouth Atlas of Health Care*, a compendium of statistics and patterns of medical spending in 306 regions of the

country. The atlas is generated by a group of nearly two dozen doctors, epidemiologists, and health-care economists, using data from Medicare, large private insurers, and a variety of other sources. Wennberg is the group's leader and the patron saint of the idea that more medicine does not necessarily mean better health—a view that has not exactly endeared him to the medical establishment over the years. These days, however, his ideas are bolstered by the Institute of Medicine and other independent researchers, and by new results coming from his Dartmouth research team, which is showing precisely how the nation misspends its health-care dollars.

Take the regions surrounding Miami and Minneapolis, which represent the high and low ends, respectively, of Medicare spending. A sixty-five-year-old in Miami will typically account for $50,000 more in Medicare expenses over the rest of his life than a sixty-five-year-old in Minneapolis. During the last six months of life, a period that usually accounts for more than 20 percent of a patient's total Medicare expend-itures, a Miamian spends, on average, twice as many days in the hospital as his counterpart in Minneapolis, and is twice as likely to see the inside of an intensive-care unit.

This type of regional variation would make perfect sense if regions where citizens were sickest were the ones that used the most medical services. After all, it's only fair that we should spend more and do more in places where people need more medical attention. But, as Wennberg and his colleagues Elliott Fisher and Jonathan Skinner point out in a recent paper, "Geography and the Debate Over Medicare Reform," which appeared online in the journal *Health Affairs*, rates of underlying illness do not account for the differences in spending among regions. If they did, the region around Provo, Utah, one of the healthiest in the country, would get 14 percent fewer Medicare dollars than the national average, because its citizens are less likely to smoke, drink, or suffer from strokes, heart attacks, and other ailments. Instead it receives seven percent more than the national average. In contrast, el-derly people in the region around Richmond, Virginia, tend to be sicker than the average American, and should be receiving 11 percent more—rather than 21 percent less—than the national average. Nor are regional differences explained by variations in the cost of care. Provo doctors are not, for example, charging significantly more for office visits or lumpectomies than doctors in Richmond, and their patients aren't getting costlier artificial hips.

Rather, much of the variation among regions—about 41 percent of it, by the most recent estimate—is driven by hospital resources and numbers of doctors. In other words, it is the supply of medical services rather than the demand for them that determines the amount of care delivered. Where neonatal intensive-care units are more abundant, more babies spend more days in the NICU. Where there are more MRI machines, people get more diagnostic tests; where there are more specialty practices, people see more specialists. It's probably safe to assume that many people are gravely ill during the last six months of their lives no matter where they live; but Medicare beneficiaries see, on average, twenty-five specialists in a year in Miami versus two in Mason City, Iowa, largely because Miami is home to a lot more specialists.

It would be one thing if all this lavish medical attention were helping people in high-cost regions like Miami to live longer or better. But that doesn't appear to be the case. Recent studies are beginning to show that excess spending in high-cost regions does not buy citizens better health. Medicare patients visit doctors more frequently

in high-cost regions, to be sure, but they are no more likely than citizens in low-cost regions to receive preventive care such as flu shots or careful monitoring of their diabetes, and they don't live any longer. In fact, their lives may be slightly shorter. The most likely explanation for the increased mortality seen in high-cost regions is that elderly people who live there spend more time in hospitals than do citizens in low-cost regions, Wennberg says, "and we know that hospitals are risky places." Patients who are hospitalized run the risk of suffering from medical errors or drug interactions, receiving the wrong drug, getting an infection, or being subjected to diagnostic testing that leads to unnecessary treatment.

An obvious way we might cut excess medical care is to change the way we pay hospitals and doctors. "Medicine is the only industry where high quality is reimbursed no better than low quality," says David Cutler, a health economist at Harvard. "The reason we do all the wasteful stuff is that we pay for what's done, not what's accomplished." Although that's clearly the case, figuring out the right incentives for health-care providers is by no means easy. Let's say that Medicare decided to use low-cost regions as a benchmark and told providers in the rest of the country that their compensation would be capped at some level not far above the benchmark. Some doctors in high-cost regions would undoubtedly be encouraged to practice more conservatively, but many others would maintain their incomes by either dropping Medicare patients altogether or giving them even more hysterectomies and CT scans they don't need (thus compensating for lower fees by simply performing a greater number of procedures).

Even if policymakers come up with the right financial incentives, restructuring compensation will constitute only one small component of the reform that's needed to turn medicine into an efficient, effective industry. Think of it this way: at 13 to 14 percent of GDP, health care is the nation's largest single industry, and probably its most complex. Transforming this sprawling behemoth is going to involve a lot more upheaval than, say, the shift that took place in the auto industry when companies adopted the assembly line, or the shake-up that Hollywood and the music industry now face with the advent of Web entertainment.

Step No. 1 toward improving the quality of health care is reducing what the Dartmouth group calls "supply-sensitive" care—the excess procedures, hospital admissions, and doctor visits that are driven by the supply of doctors and hospital resources rather than by need. Organizations such as the American Medical Association and Kaiser Permanente will need to set standards for more-conservative practices, and for measuring patient outcomes. Benchmarks are also needed to ensure that doctors deliver more "evidence-based" medicine: procedures and practices whose benefits are proven. Three recent studies, conducted by the Institute of Medicine, the Rand Corporation, and the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, report widespread underuse of evidence-based treatment, such as balloon angioplasty to open blocked arteries in heart-attack victims, even among citizens with gold-plated health insurance.

Probably the hardest part of reforming health care will be persuading policymakers and politicians that improving the quality of care can also save money. The Medical Quality Improvement Act, introduced last July by Vermont Senator James Jeffords, is a step in the right direction. It would call on several medical centers around the country to model high-quality medicine that also reins in costs.

But evidence already exists that improving quality can hold down costs. Franklin Health, a company based in Upper Saddle River, New Jersey, manages so-called "complex cases" for private insurers. Complex cases are the sickest of the sick, patients with multiple or terminal illnesses, who are also the most costly to treat. They typically make up only one or two percent of the average patient population while accounting for 30 percent of costs. Franklin employs a battalion of nurses, who make home visits and spend hours on the phone, sometimes every day, to help patients control pain and other symptoms and stay out of the hospital. For this low-tech but intensive service the company charges insurers an average of $6,000 to $8,000 per patient—but it saves them $14,000 to $18,000 per patient in medical bills.

How much money is at stake? If spending in high-cost regions could somehow be brought in line with spending in low-cost regions, Medicare alone could save on the order of 29 percent, or $59 billion a year—enough to keep the Medicare system afloat for an additional ten years, or to fund a generous prescription-drug benefit for seniors. And there's no reason to believe that doctors and hospitals behave any differently toward their non-Medicare patients. That means the system as a whole is wasting about $400 billion a year—more than enough to cover the needs of the 41 million uninsured citizens.

The last attempt at reforming the U.S. health-care system failed in large measure because of fears of rationing. Reform was viewed as an effort to cut costs, not to improve health, and voters believed, rightly or wrongly, that they would end up being denied the benefits of modern medicine. Future efforts at reform are going to have to persuade Americans and their doctors that sometimes less care is better.