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More Care is Not Better Care

Regional differences show that spending more does not improve – and may hurt – patients. More accountability can help.

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Health care spending likely will continue to increase dramatically over the next decade, threatening public budgets and private sector productivity (and jobs) while increasing the number of uninsured. Some argue that increased spending is the inevitable consequence of an aging population and rapidly advancing technology and that what we really need are more specialists and more hospitals.

But recent evidence demonstrates that, when comparing similar patients, those that receive a greater number of services may also actually receive the same — or in some cases lower — quality of care. How did the current situation come about? And how can we change this equation to better use precious healthcare dollars to increase quality for all?

The Evidence on Regional Differences in Spending and Quality

Recent research documents the causes and consequences of the remarkable variations in per-capita spending observed across U.S. communities [Figure 1]. Since John Wennberg published his seminal 1973 article on geographic variations in practice, we have known that nearly two-fold differences in per-capita health care spending exist across U.S. communities.[1] Age-sex-race adjusted Medicare spending in Manhattan, NY for example was $10,550 in 2000, but was only $4,823 in Portland, OR.

And it's not just that people are sicker in New England than the Northwest or that price of a visit or service is more in Manhattan than Kansas City. The regional differences in spending are largely unrelated to differences in illness or price or to differences in rates of major surgical procedures. In fact, spending on major procedures (like inpatient surgery) represents a small proportion of overall spending on physician services.[2]

Most of the differences in spending are due to greater use of the hospital as a site of care — and to more frequent physician visits and specialist consultations, and the diagnostic tests, imaging services, and minor procedures that are the almost inevitable result of a physician encounter. In addition, since 1993, the number of different physicians involved in a given patient's care has increased substantially — and the growth is most rapid in the highest spending regions.[2]

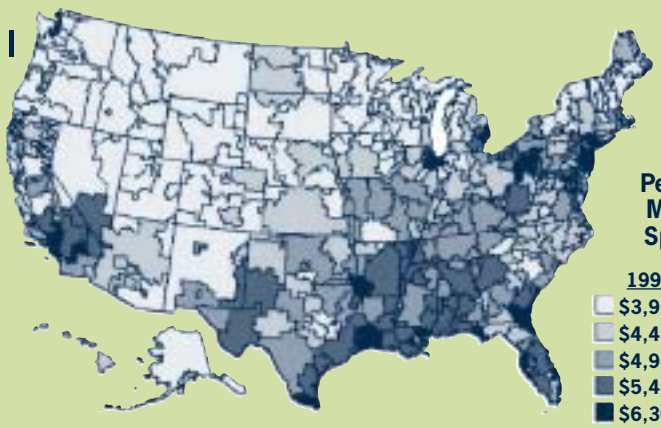
In other words, the regional differences in spending are due to the more inpatient-based and specialist-oriented pattern of practice found in high spending regions. Compared to similar enrollees in Portland, OR, Medicare enrollees in Manhattan spent more than twice as much time in the hospital and had twice as many physician visits per year. When seriously ill, they were three times as likely to spend a week or more in an intensive care unit, and had five times as many medical specialist visits.[1]

Does Higher Spending Buy Higher Quality?

Although many Americans believe more medical care is better care, evidence indicates otherwise.[3-5] Evidence suggests that states with higher Medicare spending levels actually provide lower quality care. Medicare enrollees in regions with a high intensity pattern of practice have slightly worse access to care, no better satisfaction with care, and receive lower quality care than those in regions with the more conservative practice patterns [Figure 2]. (Quality measures in this study included whether a patient with acute myocardial infarction received in-hospital or discharge aspirin, ACE inhibitor and/or beta blockers.)

Moreover, for patients with serious illnesses (hip fracture, colorectal cancer, acute myocardial infarction) the higher intensity

Figure 1



SOURCE: *Dartmouth Atlas of Healthcare*. 2003.

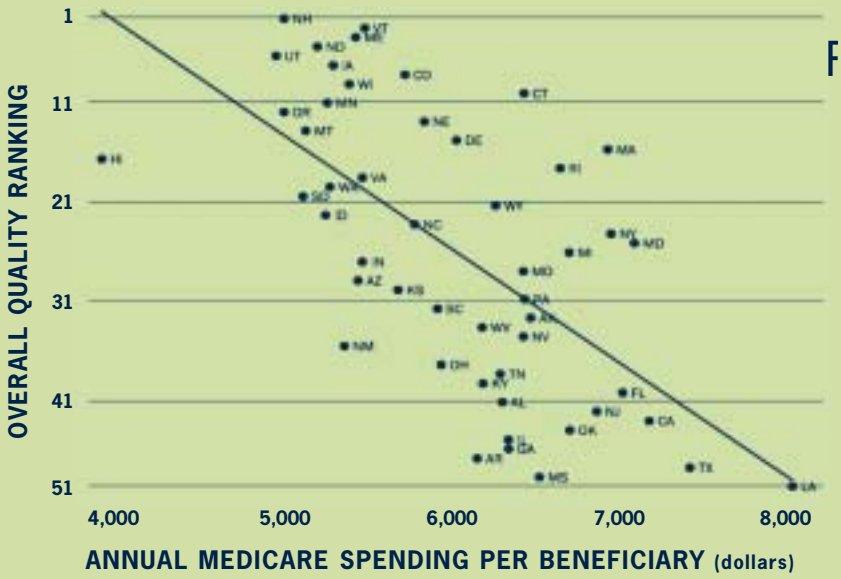


Figure 2

Baicker, K. and Chandra, A. Medicare Spending, The Physician Workforce, and Beneficiaries Quality of Care. *Health Aff (Millwood)*, 2004; Suppl Web Exclusives:W4-184-197.

practice pattern was associated with a higher risk of death over time. In other words, when comparing identical patients in high and low spending regions, those in high spending regions spent more time in the hospital and saw more physicians (more frequently) but received lower quality care and achieved worse health outcomes.[2]

These findings have serious implications for the efficiency of our health care system. Regional patterns of medical practice are similar for Medicare and non-Medicare patients (residents of New York and Philadelphia get much more care that patients elsewhere, regardless of age.) We may be wasting perhaps 30% of U.S. health care spending on medical care that does not appear to improve our health. The findings raise two important questions: What are the underlying causes of the variations in spending? What should we do about it?

Underlying Causes for Regional Differences

High spending areas of the U.S. are characterized by a substantially higher per-capita supply of hospital beds and medical specialists. We've known for many years that patients in regions with more physicians have more frequent visits; those in regions with more specialists are more likely to see specialists, and those in regions with more hospital or ICU beds are more likely to spend time in the hospital or ICU. We now know that these differences in capacity drive spending for two reasons:

- Current financial incentives virtually ensure that existing (or additional) health care resources will remain fully utilized. Most physicians are still paid more only when they do more and hospitals, ambulatory surgery centers, and imaging services depend upon a continued flow of patients to meet their expenses. And very sick patients — remember about 80% of health care spending is devoted to the sickest 20% of the population — are likely to have met deductibles, co-pays and out-of-pocket maximums, which are designed to decrease unnecessary care.
- And most people still believe that more medical care means better medical care. News reports promote the latest medical breakthroughs (often based upon preliminary reports of studies that are never published). The pharmaceutical industry provides a daily barrage of misleading advertising. And most patients have learned to believe that any limits on choice or access only exist to save money, not improve quality.

What Can We Do About It?

Support more research on medical outcomes of commonly performed procedures. We need much better information on the risks, benefits and uncertainties of specific interventions and on the quality and costs of the systems where we receive our care. Coronary angioplasty, for example, is performed over one million times each year in the United States, often for stable angina.[6] For this indication, however, fewer than 5000 patients have ever been enrolled in randomized trials and we still don't know whether angioplasty is more or less effective than drug treatment. In the absence of accurate and balanced information that helps patients understand that nearly every treatment choice has both benefits and risks, more care will always look like better care.

Take steps to control further growth in the capacity of the health care system. The benchmarks provided by U.S. regions with conservative practice patterns indicate that we already have more physicians and hospital beds than we need. Apparent shortages of beds in some regions may reflect the role of the hospital as the provider of last resort for the uninsured and the care fragmentation and inadequate primary care that characterize a specialist-dominated system. Apparent shortages of certain medical specialties almost certainly result from current reimbursement formulas that may over-reward some procedures. The recently adopted temporary freeze on the growth of specialty hospitals is an important step in the right direction.

Learn how to measure and improve the "longitudinal efficiency" of care. The costs of caring for a patient or a population are determined not only by the price of a given service but also by the overall quantity of services delivered over time — what some are now referring to as "longitudinal efficiency". Recent research has begun to reveal which hospitals are most efficient in treating chronically ill patients.[7] The development and adoption of provider-specific measures of longitudinal efficiency and quality would allow payers to identify and reward high performing health care organizations. In turn, we can begin to reassure patients that excellent care and lower costs are compatible.

In summary, we need to help patients begin to understand that more care is not always better care — and in fact may be worse.

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Notes

1. *Dartmouth Atlas of Healthcare*. 2003.
2. Fisher, E.S., et al. Variations in the longitudinal efficiency of academic medical centers. *Health Aff (Millwood)*, 2004; Suppl Web Exclusives:W4-19-32.
3. Baicker, K. and Chandra, A. Medicare Spending, The Physician Workforce, and Beneficiaries Quality of Care. *Health Aff (Millwood)*, 2004; Suppl Web Exclusives:W4-184-197.
4. Fisher, E.S., et al. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of Care. *Ann Intern Med*, 2003; 138(4):273-87.
5. Fisher, E.S., et al. The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with Care. *Ann Intern Med*, 2003; 138(4):288-98.
6. Kolata, G. The limits of opening arteries. *The New York Times*. 2004: New York. p. 12.
7. Wennberg, J.E., et al. Use of hospitals, physician visits, and hospice care during last six months of life among cohorts loyal to highly respected hospitals in the United States. *BMJ*, 2004; 328 (7440):607.