CECS
Center for the
Evaluative
Clinical Sciences

The paradox of plenty

Inefficiency in U.S. health care -- and what we can do about it

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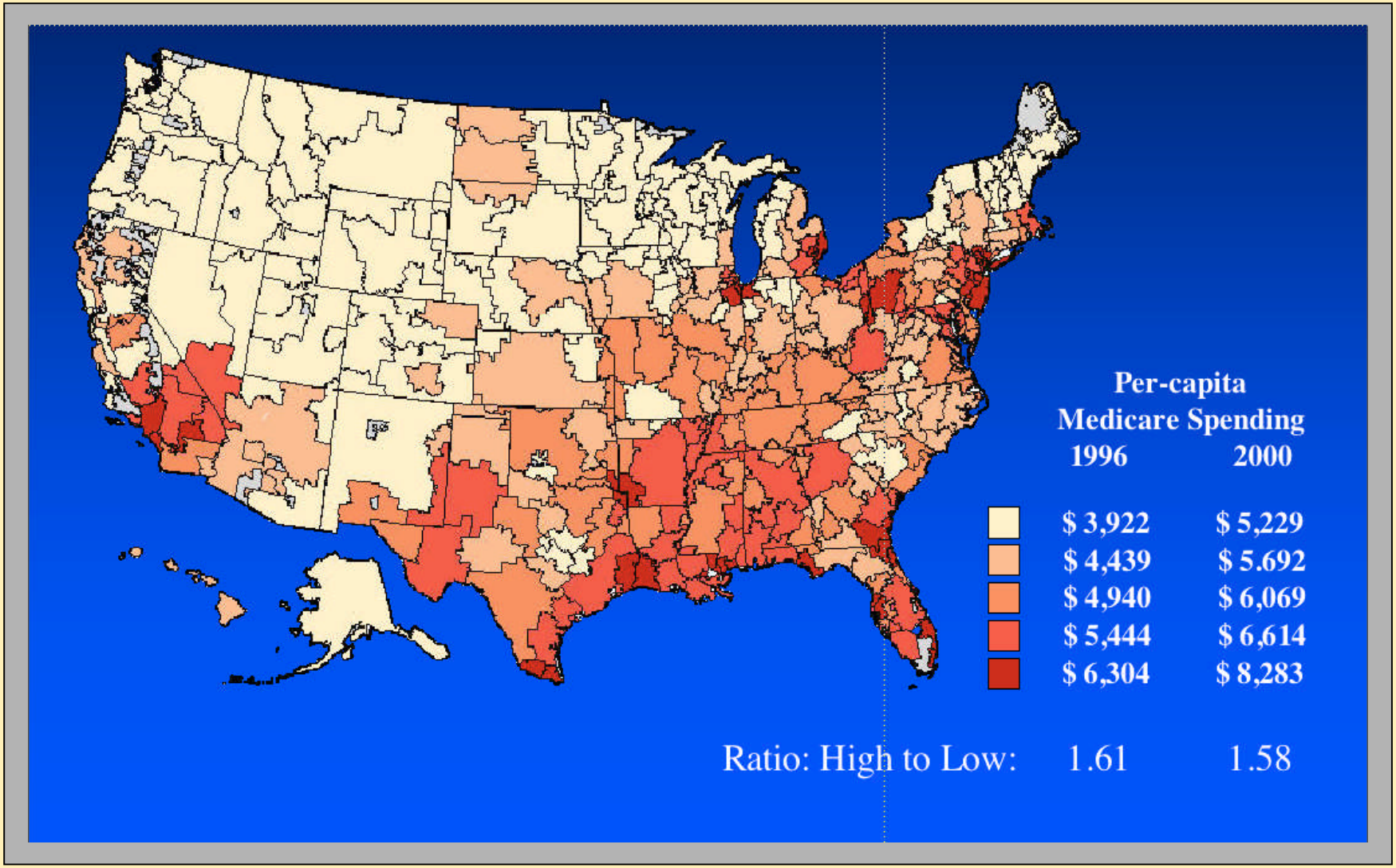

How can the best medical care in the world cost twice as much as the best medical care in the world?

Uwe Reinhardt

The paradox of plenty

What do higher spending regions -- and systems -- get?

Content / Quality of Care[1,2]	*Technical quality worse*
	No more elective surgery
More supply-sensitive care	*More hospital stays, visits, specialist use, tests*
Health Outcomes[1,2]	*No better, possibly higher mortality*
	No better function
Physician's perceptions[5]	*Worse communication among physicians*
	Greater difficulty ensuring continuity of care
	Greater difficulty providing high quality care
Patient-perceived quality[1,3]	*Lower satisfaction with hospital care*
	Worse access to primary care
Trends over time[4]	*Greater growth in per-capita resource use*
More supply-sensitive care	*Lower gains in survival (following AMI)*

(1) Ann Intern Med: 2003; 138: 273-298
(2) Health Affairs web exclusives, October 7, 2004
(3) Health Affairs, web exclusives, Nov 16, 2005
(4) Health Affairs web exclusives, Feb 7, 2006
(5) Ann Intern Med: 2006; 144: 641-649

Major points

Higher spending across regions and physician groups is largely due to overuse of *supply-sensitive services* -- hospital and ICU stays, MD visits, specialist consults, imaging and testing; *and more is worse*.

What's going on?

What explains the differences in practice?

Patient preferences -- can't explain the differences observed

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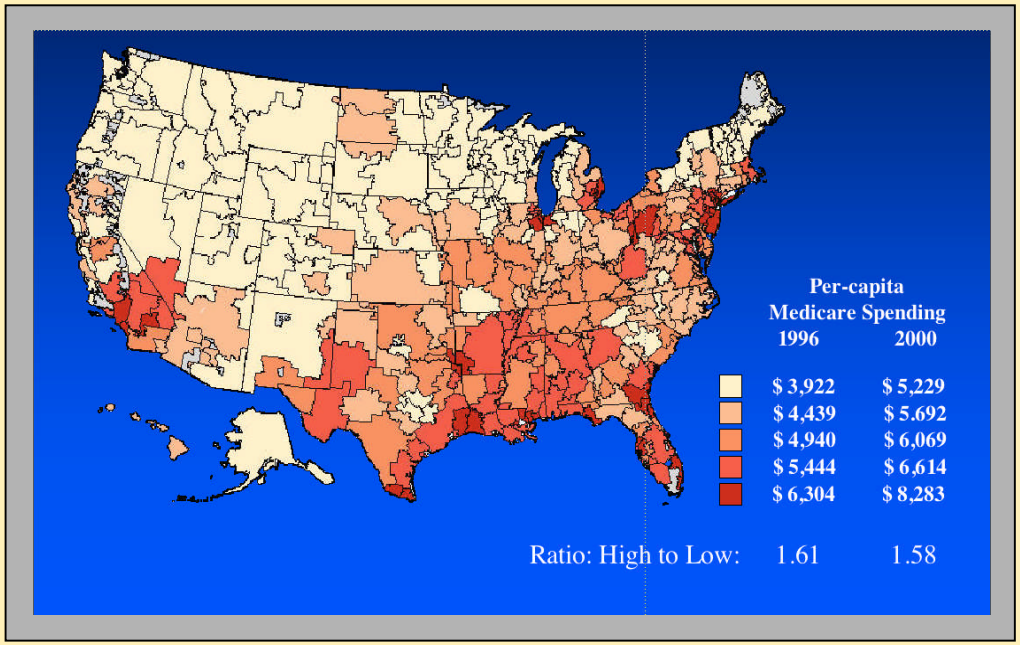
Capacity and payment -- are important drivers



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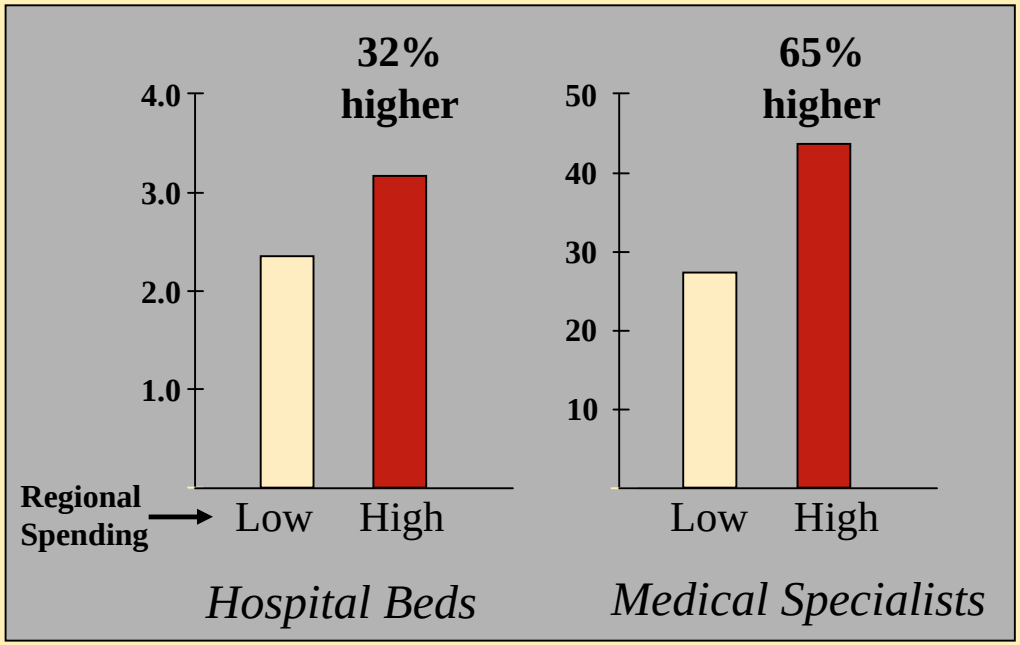

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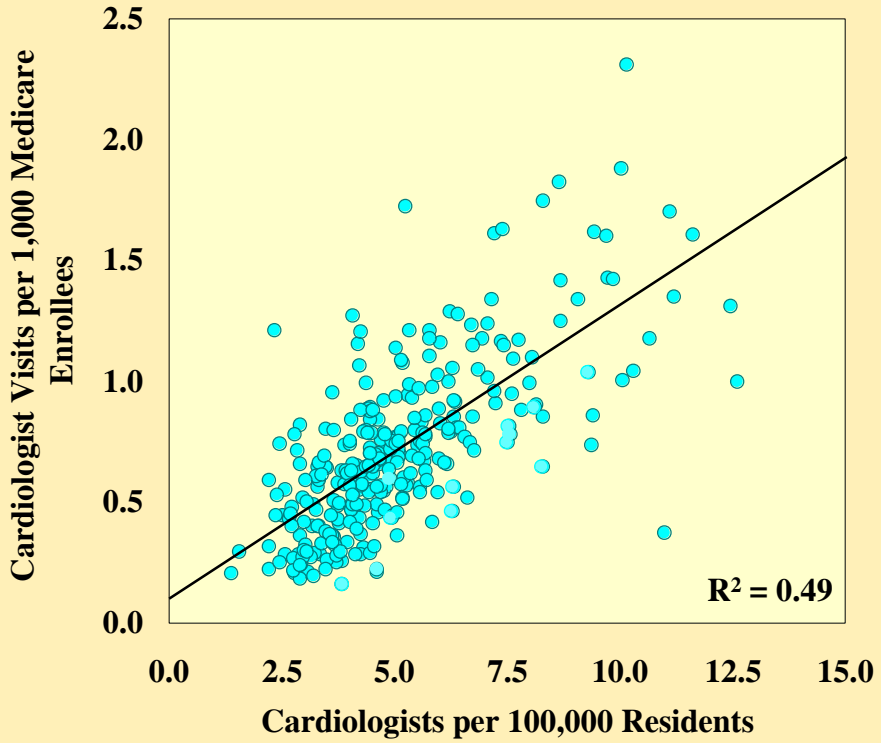
Whatever capacity is in place will be fully utilized



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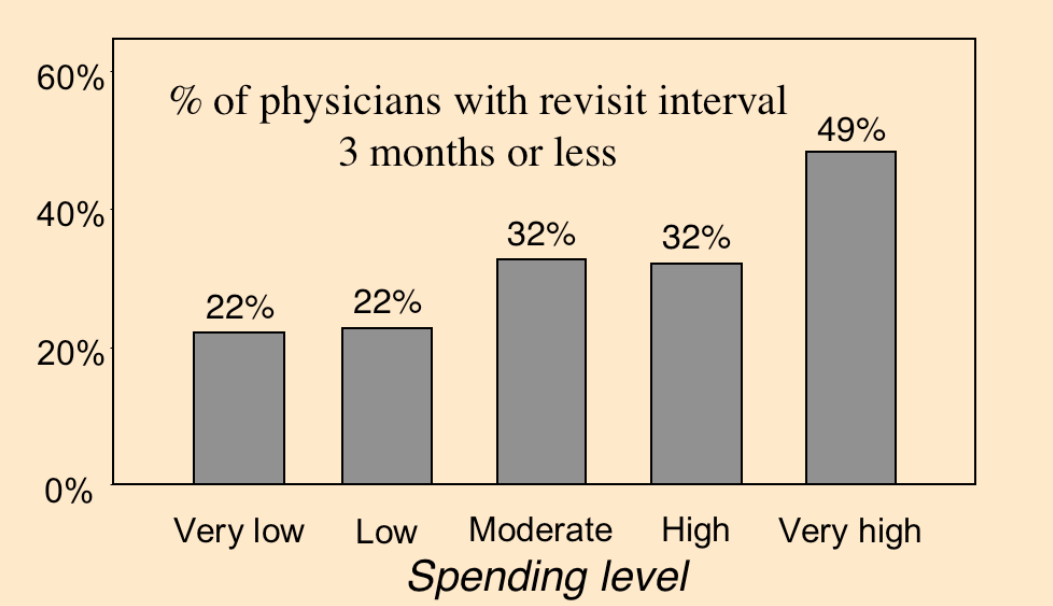
Clinical decision-making -- in the gray areas -- is critical



Putting together a story…

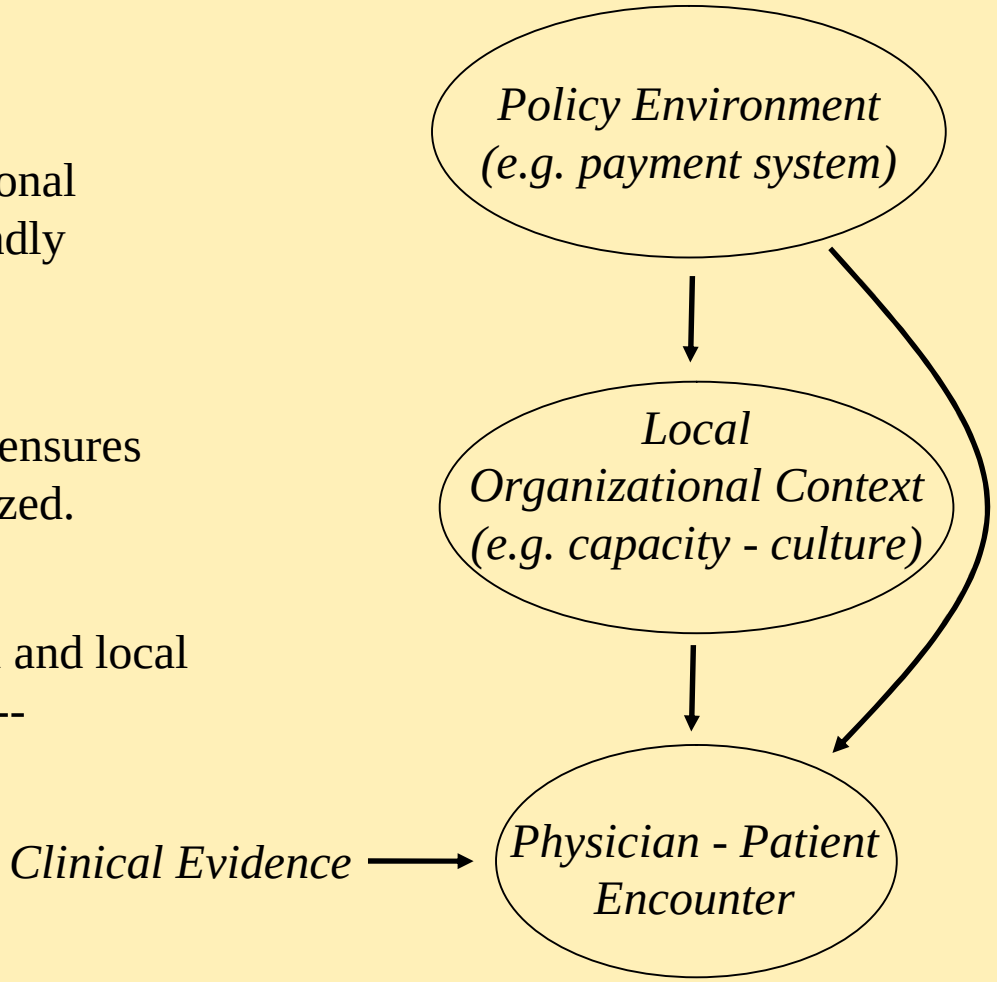
Clinical evidence (e.g. RCTs, guidelines) is a critically important -- but limited -- influence on clinical decision-making.

Physicians practice within a local organizational context and policy environment that profoundly influences their decision-making.

Current payment system fosters growth and ensures that existing (and new) capacity is fully utilized.

Consequence: *reasonable* individual clinical and local decisions lead, in aggregate, to higher costs -- and inadvertently -- to worse outcomes.

More tests and "incidentalomas"
More time in the hospital
Greater complexity (more MDs)



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Higher spending across regions and physician groups is largely due to overuse of *supply-sensitive services* -- hospital and ICU stays, MD visits, specialist consults; *and more is worse.*

Overuse is largely a consequence of reasonable differences in clinical judgment (***not errors***) that arise in response to local organizational attributes (***capacity***, ***clinical culture***) and policies promoting fragmentation, growth and more care.

What about current policy initiatives?

Focus largely on individual providers and their silos

Face substantial technical challenges

- Limited scope of measurement risks making bad apples (on unmeasured domains) appear good.
- “Efficiency” measures target brief episodes and largely ignore the role of volume (frequency of episodes)

What about current policy initiatives?

Focus largely on individual providers and their silos

Face substantial technical challenges

Ignore the organizational context of care: *and the decisions about capacity that drive overuse and excess spending*.

Improving efficiency

Foster organizational accountability for quality and costs

Policy initiatives should focus on fostering organizational accountability for *longitudinal* quality and costs.

Formal: Prepaid / multi-specialty group practices (e.g Kaiser)

Virtual: Hospitals and their affiliated physicians

Hospitals / Medical Staff

Majority of physicians work in or admit to only one hospital

Chronic disease patients are highly loyal -- allowing comparisons of longitudinal costs and quality

Performance measurement -- and payment reform -- would create incentives for hospital and staff to collaborate to improve quality

Provides organizational context for capacity management -- and for implementation of information technology, QI, shared decision-making

Dartmouth Atlas of Health Care

The care of patients with severe chronic illness

Goal -- provide hospital specific measures of relative intensity of resource use

Approach -- measure resource use in severely ill patients

- Assign Medicare beneficiaries to hospitals based upon predominant site of care during last 2 years of life (with chronic illness)
- Adjust for differences in underlying illness
- Measures include: Medicare reimbursements, utilization rates.

Importance

- Measures reflect relative intensity and costs for other populations
- Provide insight into *volume* of supply-sensitive services (a reflection of capacity and culture)

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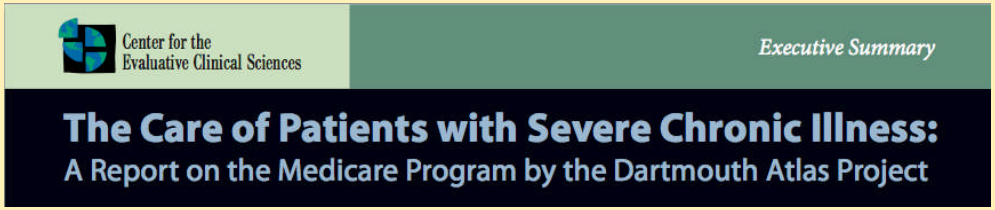
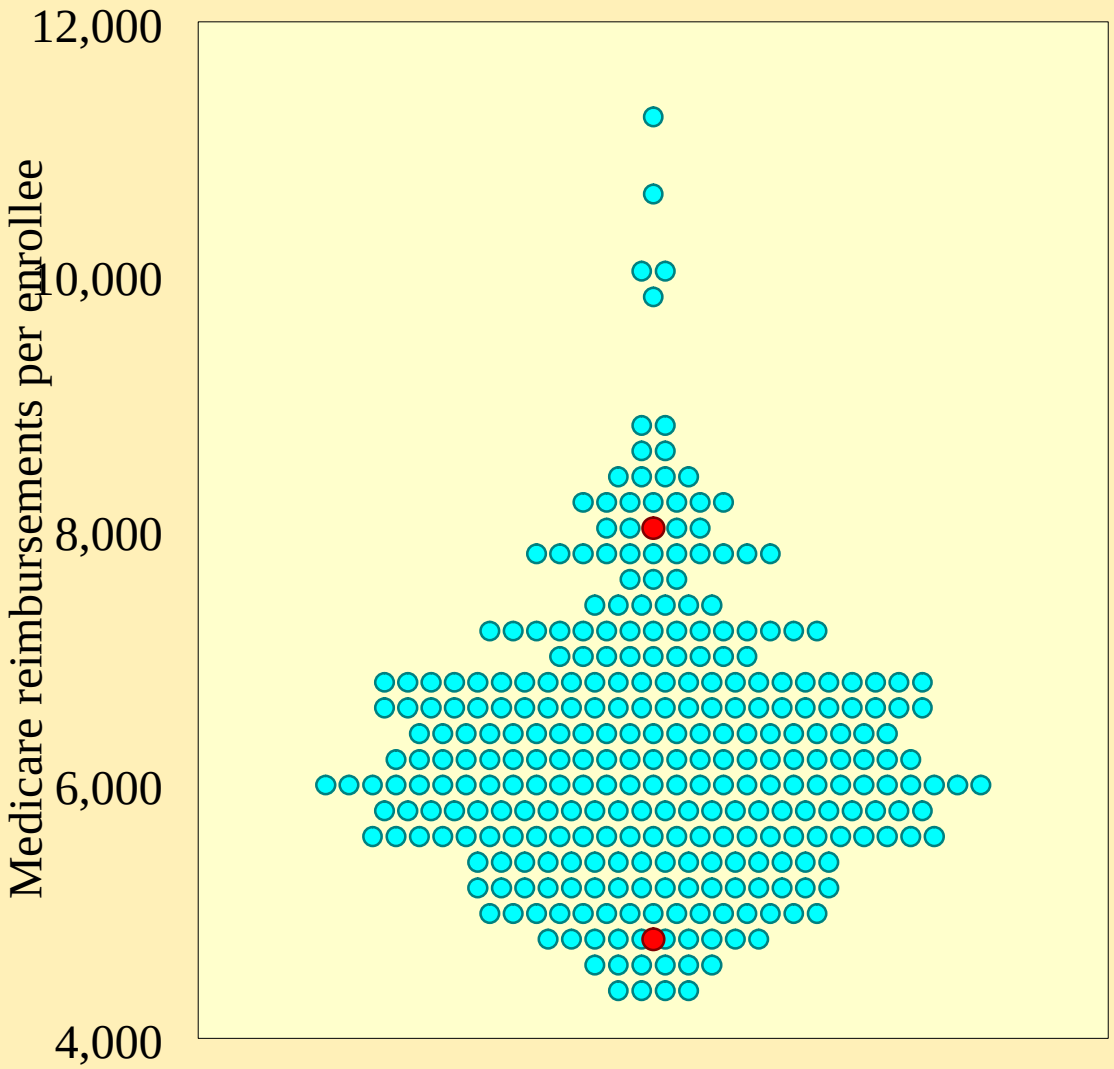


Total Medicare (Parts A and B) reimbursements

All fee-for-service Medicare enrollees, U.S. hospital referral regions (2003)



Fort Lauderdale, FL **$8,045**

Sayre, PA **$4,764**

Spending and utilization among ***severely ill patients*** in Fort Lauderdale, FL and Sayre, PA HRRs

(all deaths occurring 2000-03)

Measure	Fort Lauderdale		Sayre	
	Medicare Beneficiaries All Hospitals Combined		Medicare Beneficiaries All Hospitals Combined	
Inpatient & Part B spending*	$39,262		$26,296	
	Delray Med Center	Imperial Point Med Ctr	Robert Packer Hospital	Memorial Hospital Towanda
Inpatient & Part B spending	$44,217	$34,280	$29,693	$21,362
Hospital days	17.0	13.4	13.2	9.5
Primary care visits	17.5	18.0	10.4	11.4
Medical specialist visits	42.8	21.3	16.4	2.8

*weighted average -- all hospitals

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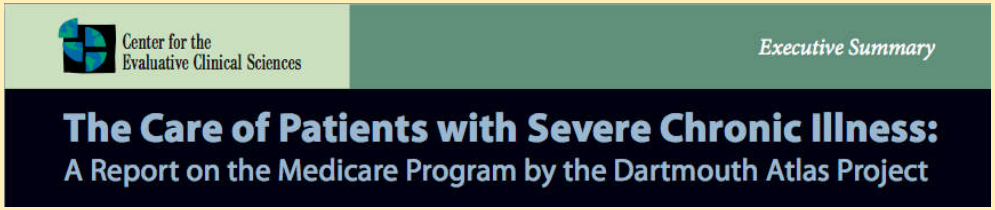

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Performance measurement and payment reform will be critical.