REMAPPING DEBATE
Asking "Why" and "Why Not"

Keeping the “best care” option out of the health spending equation

Original Reporting | By Mike Alberti | Health care, Insurance, Quality of life

Feb. 27, 2013 — If there is a single message that has come to dominate the debate over health care in the United States in the last several years, it is that Americans are receiving too much of it.

The idea that there is rampant “overutilization” of medical services in the U.S. health care system has been embraced by top officials in the Obama administration, by the Institute of Medicine, and by economists and policy experts of all stripes.

> “You can name any disease or condition that you want, and I can guarantee that there’s underutilization of an effective treatment happening. The literature is replete with studies that show people not getting things they should be getting.” — Patrick Alguire, American College of Physicians.

The appeal of this idea to policy makers who are focused on reducing the federal deficit is clear: once it is accepted that overutilization is a serious problem, it is a small step to claim that we would save a significant amount of money merely by providing the “right” amount of care. We could, the argument goes, cut out a lot of fat without any risk to our health.

“There are a lot of tests done, a lot of procedures, a lot of hospital admissions which we really know scientifically cannot help the patient,” Donald Berwick, the former administrator of the Center for Medicare and Medicaid Services in the Obama Administration, said in a 2009 interview prior to his appointment to that position, “I think working hard on the overuse of ineffective practices is a very good way for us to save money and not harm a hair on a patient’s head.”

Much of health care policy, public and private, in the last several years proceeds from (or is rationalized by) this premise. The Patient Protection and Affordable Care Act (ACA), for example, includes an excise tax on relatively expensive health insurance plans, often referred to as the “Cadillac tax.” The tax is intended to make the most generous plans less so, on the theory that people with those “luxury” plans are selfishly and heedlessly consuming too many medical services.

But a thorough examination of the argument by Remapping Debate found only limited direct evidence of “overutilization.” We also found that the claim that utilization could be reduced at no risk to patient health has been oversold.

In many cases, the investigation found, the argument for reducing costs ignores the question of how to provide the *best* care to the greatest number of people and does not grapple with *under*-utilization of medical care (a problem that is more widely acknowledged by experts than is generally realized). The argument, it would appear, is based principally on the assumption that we have “no choice” but to cut back on “unsustainable” levels of health care spending, with little concern paid to whether fat or muscle is being cut.

The missing option

According to several experts and observers, demoting or ignoring “best quality” concerns is not a trivial matter. Jonathan R. Cole, a sociologist and a professor of the university at Columbia University, pointed out that transparency is an essential element of public policy decision-making. Choices, he said, need to be presented “in a way that is [at least] conducive to deliberative outcomes” in a democratic society.

Different people will have different definitions of what constitutes “gold standard” care, he said, but “simply articulating what that standard is and making sure one can [analyze its component parts closely] would be very helpful.”

Cole, while arguing strongly in favor of more rigorously evaluating the efficacy of various medical procedures, rejected the notion that there is only a single policy choice when it comes to spending on health care: “If a society wishes to spend a lot of its resources on the health of its people… the society ought to be able to increase its part of GDP that goes to health care, especially [if] it has an aging population, which will get rebalanced at some point in time.”

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Those considerations along with similar quality-of-care and healthfulness-of-society concerns expressed by other observers, are, Remapping Debate found, precisely the ones that have been absent from mainstream debate and discussion about health care.

James Colgrove is an associate professor of sociomedical sciences at Columbia University’s Mailman School of Public Health. Asked about the need to identify what would be required of a health care system in order to secure for each person all beneficial follow-on medical interventions, Colgrove noted that the question had both an empirical component and an ethical component, the latter derived from a sense of “what it is that is due to people” according to a theory of justice. Whether the empirical discussion should precede the ethical discussion, or, as Colgrove suggested, the ethical discussion should come first, the reality, he agreed, was that *both* of those discussions are being left out of current political debate.

Colgrove added that the idea that “demagoguery passes for public debate” in the health care context “hits the nail on the head.” Discussions are warped, he continued, by dominant cultural beliefs about individual responsibility and what the “quote-unquote ‘free market’ does, or should do for us.”

“It is,” Colgrove concluded, “a deeply ingrained part our of our political culture that we treat health care like a commodity.”

What happens if the United States just proceeds with various cost-cutting schemes without examining what an alternative system would look like and cost if it provided the kinds of quality care that people would want for themselves and their families (given our current state of knowledge)? It is a fair summary, Professor Cole said, to describe such a process as one that deprives the public of the ability to know what policy options it is being asked to give up — precisely because not all of the options are allowed to be visible.

An imaginary number?

In discussions about waste and overutilization, it is frequently claimed that 30 percent or more of U.S. spending on health care could be eliminated without any effect on patient health.

In large part, that figure is derived from the findings of researchers at the Dartmouth Institute for Health Policy and Clinical Practice, a group that produces the much-cited Dartmouth Atlas of Health Care. The Dartmouth group was highly influential in the debate over health reform in 2009. Yet material questions remain about the significance of the data on which the group relied.

Researchers at Dartmouth arrived at the figure of 30 percent by comparing Medicare spending and outcomes in different regions of the country. They found that the amount of spending on health care varies widely, often does not correlate with better outcomes, and that if each higher-cost region in the country reduced its spending to the level of the low-spending, high-quality regions, savings of 30 percent or more are possible.

These findings have frequently been deployed as evidence that one-third or more of national spending on health care is wasted on unnecessary tests and procedures, and that it is possible to reduce the amount of utilization without worsening outcomes.

However, as Remapping Debate’s investigation found, there is a meaningful gap between the *indirect* evidence that is represented by the findings on regional variation and *directly* observed and measured evidence for specific procedures. According to several experts, this gap has profound implications for policy makers attempting to cut back on overutilization, and calls into question the idea that utilization can be reduced with little or no risk to patients.

The most comprehensive review of the direct evidence of overutilization was published last year in the Archives of Internal Medicine. The study, which was led by Deborah Korenstein, an associate professor of general internal medicine at the Icahn School of Medicine at Mount Sinai Hospital in New York, reviewed the literature on overutilization from 1979 to 2009 and found that "the robust evidence about overuse in the United States is limited to a few [medical] services."

In her literature review, Korenstein was able to identify fewer than three dozen medical procedures for which there was evidence of inappropriate use, and for the majority of those procedures, she said, the evidence was limited to one or two studies. The majority of the studies focused on the same four procedures.

When placed up against the lack of direct evidence of overutilization, Korenstein said, the 30 percent figure, "is kind of imaginary. It's not based on any real knowledge."

THRILL-SEEKING PATIENTS?

Arthur MacEwan, a professor emeritus of economics at the University of Massachusetts Boston, pointed out that the common argument that insurance coverage that is "overly generous" leads patients to get more care than is good for them rests on the assumption that people enjoy receiving health care and actively seek it out.

This assumption, he said, was "not likely to hold up under scrutiny."

"I think most people will generally do what their doctor tells them to and nothing more," MacEwan said. "There may be some outliers in terms of people requesting MRIs and that sort of thing, but most people trust their doctor and defer to [his or her] judgment."

Indeed, Don McCanne, senior health policy fellow at Physicians for a National Health Program, said that if anything, people are more likely to feel inhibitions about getting even a minimal amount of care than they are eager to seek out care that is not prescribed to them.

Especially if a patient is unhealthy, he said, going to the doctor can be a demoralizing experience, one that many would rather avoid unless it became absolutely necessary."I don't think people perceive of going to the doctor as a fun activity," McCanne said.

"If they did, we might see more people getting their recommended colonoscopies."

According to Geraldine McGinty, chair of the Commission on Economics at the American College of Radiology, arguments about overutilization are also complicated by the fact that there is some degree of uncertainty about the benefits of many procedures.

"As soon as you start making clinical appropriateness guidelines, you see that there are big gaps in our knowledge about the effectiveness of different treatments," she said. "Defining what's appropriate is sometimes kind of an arbitrary decision."

"These numbers get dangled in front of policy makers to tempt them into thinking we can cut costs and not hurt anyone, but a lot of [the] push to cut overutilization is based on circumstantial evidence," said Mark Pauly, a professor of health care management at the University of Pennsylvania.

If Pauly is right, and the circumstantial evidence proves less valid than is commonly thought, then the soundness of the entire foundation underlying the argument that costs can be cut significantly without harming patient care by reducing utilization would be in serious question.

Scalpels or chainsaws?

Pauly added that overselling the idea that services are broadly overutilized creates the incentive for policymakers to attempt to realize savings by cutting utilization indiscriminately, with the result of reducing access to beneficial services in the process.

"If anyone tells you that they can get meaningful savings out of reducing waste in a way that's guaranteed to do more good than harm, they're trying to sell you something," he said.

Further complications arise because even those procedures that experts agree are broadly overused are still beneficial for the majority of patients who receive them.

"There is always the risk that in an effort to squeeze things out generally, you're going to squeeze out some things that should be done," said Henry Aaron of the Brookings Institution. "We have no way [to reduce overutilization] surgically."

For example, there is a broad consensus that cardiologists implant more coronary stents, which are small metal tubes that are placed inside heart arteries to keep them open, than are medically necessary. But James Fasules, a pediatric cardiologist and the senior vice president of advocacy at the American College of Cardiology, said that about 70 percent of stents are used in emergency situations, such as when a patient is having a heart attack, and are not medically controversial. Of the remaining 30 percent, he said, many would still be considered medically necessary.

According to Robert Berenson, an internist and a fellow at the Urban Institute, the fact that many overutilized procedures are still medically necessary much more often than not makes it very difficult to reduce the unnecessary care without impacting necessary care.

"You can't just go in and whack the payment for those areas," he said. "The truth is that it is incredibly difficult to take out the waste without doing harm."

Putting the squeeze on

In interviews with Remapping Debate, many physicians said that they have already felt a change in the environment within which they attempt to provide patients with quality care, and gave examples of certain beneficial procedures that have become especially discouraged.

McGinty of the American College of Radiology said that she has noticed that it is more difficult than it used to be to order magnetic resonance images (MRIs) because insurance companies are less likely to approve them. "There is an entire infrastructure set up by the insurance companies to manage imaging," she said. "I'm a believer that a lot of unnecessary imaging gets done, but by making it harder to get *any* imaging done, we're putting a lot of patients [who legitimately need those MRIs] through additional pain and anguish."

Linda Cox, president of the American Academy of Allergy, Asthma & Immunology, said that insurance plans have become less willing to pay for pulmonary-function testing, which help physicians assess the severity of lung conditions such as asthma and cystic fibrosis. “Some plans say you can only get one test a year,” Cox said. “But typically you’re going to want to do one test, prescribe a treatment, and do another one some time later to determine if the treatment is working. That’s textbook. We can’t even follow our own guidelines.”

Many physicians were also quick to bring up medical services that they fear will become more difficult to perform because of the cut-cut-cut tenor of the discussion. John Fildes, a chief of the Division Trauma and Critical Care at the University of Nevada School of Medicine, said that many patients benefit greatly from rehabilitative services after a traumatic accident.

“If you’ve had a brain injury or a spinal injury, you’re going to benefit almost as much from intensive rehab as from the initial surgery,” he said. “I worry that in our conversations about cutting waste we forget how important those kinds of services are.”

Bruce Sigsbee, the president of the American Academy of Neurology, said that for certain neurological conditions like multiple sclerosis and epilepsy, there is often only one effective drug that the patient can tolerate. “Do we really want to make it harder for people the get that drug just because it happens to be the most expensive?”

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What about underutilization?

According to many experts, the discussions about the overutilization of medical services have often failed to take into account a much more well-documented problem: the underutilization of medical services.

The most comprehensive studies from the last decade have found widespread underutilization. The first study to attempt to measure the amount of medical care that is utilized in the general population, in 2003, found that American adults received barely more than half of the recommended care. In 2007, another study found that American children receive less than half of recommended care.

“You can name any disease or condition that you want, and I can guarantee that there’s underutilization of an effective treatment happening,” said Patrick Alguire, the senior vice president for medical education at the American College of Physicians. “The literature is replete with studies that show people not getting things they should be getting.”

While underutilization is most acute among people that have no insurance and therefore extremely limited access to medical care of any type, Alguire said that it is also a serious problem in the insured population, especially as high cost-sharing provisions deter people from receiving beneficial care. A 2008 study published in *Health Affairs* found that more than 25 million adults in America were underinsured in 2007. More recent research has demonstrated that people with low-quality health insurance frequently forgo beneficial care.

Experts often point to examples of underutilization, such as underutilization of primary care services, that, if made more widely available, may actually save money in the long run. Still, Steven Asch, a professor of medicine at the Stanford University School of Medicine who has long studied both over- and underutilization said that "the costs of bringing people who aren't getting enough care up to the appropriate level is certainly a very large number."

When asked whether those costs could be balanced by the savings from reducing overutilization, Asch said that that was "far from clear."

Eve Kerr, a professor of internal medicine at the University of Michigan who has also studied both over- and underutilization, explained that many of the policies that have been proposed to reduce overutilization not only ignore the problems posed by underutilization, but actually risk exacerbating those problems.

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"If we use too blunt an instrument to try to cut out costs, we are going to decrease overutilization but also increase underutilization," Kerr said. "In our rush to cut costs, we aren't focusing on the right person getting the right care. We're focusing on decreasing the amount of care, full stop."

Indeed, according to Daniel Barocas, a urologic oncologist and assistant professor of medicine at Vanderbilt University Medical Center, recent research suggests that blunt attempts at decreasing inappropriate care can have the effect of reducing access to appropriate care, a phenomenon that has been dubbed the "thermostat effect."

"If people are just being urged to hold back on something, they're likely to do less of the good kind of imaging and less of the bad kind," Barocas said. "You squeeze out the good with the bad."

Cutting waste or cutting cost?

Remapping Debate interviewed several proponents of putting policies in place that are aimed at curbing overutilization, and asked them to identify the specific procedures for which they would like see reduced utilization.

We can do it — cheaply!

Health care plans that supposedly provide "Cadillac" care have been under attack for years. Charging that users of those plans get overly generous tax subsidies (through the receipt of non-taxable health insurance benefits) for overly generous health insurance, and waving the banner of "efficiency," those seeking to ratchet down benefits successfully pushed a "Cadillac tax" as part of the Affordable Care Act. The Cadillac tax will impose an annual excise tax of 40 percent on the value of plans that exceed a specified cap, ($10,200 for individuals and $27,500 for families in 2018) which will rise each year at a rate slightly greater than that of inflation. One hope of Cadillac tax advocates is that insurance companies will move away from providing Cadillac plans.

Jonathan Skinner is a professor of economics who is affiliated with the Dartmouth Institute for Health Policy and Clinical Practice and has written extensively about overutilization of health care. Skinner does acknowledge that *under*-utilization of medical services is a problem, but believes that insurance companies are "trying to figure out how to make sure that the stuff that patients really need [is given to them], and to try to discourage the stuff that they don't need."

But what is the evidence that insurance companies would try to save money by distinguishing between cutting fat and cutting muscle? Is there any evidence that insurance companies are perfectly rational actors? Skinner, laughing, said that "they'd like to be," but in an answer to a follow-up email inquiry asking about an alternative system that would target waste and spare necessary care (in contrast to the more blunt tool of either a Cadillac tax or acting on the assumption that the only problem is overutilization), he wrote that "I think that accountable care organizations" — groups made up of physicians and other health care providers that don't bill on the basis of individual services rendered, but rather receive a fixed amount of money to provide all necessary medical care to a defined number of patients — "are probably the best option."

Would examining the costs and benefits of providing "gold standard" care to everyone enhance the debate over what direction to take in health care policy? Repeated inquiries to Skinner did not yield a direct answer.

In one email exchange, Skinner was asked about the public policy utility of estimating the cost of providing the highest quality of care to all. "I don't understand the idea of the 'highest possible quality,'" he responded. "Think of cars — what's the highest possible quality of cars? I think a Camry does the job pretty well, but you might like a Lexus and someone else might like a Maserati."

Pursuing this line of inquiry, Remapping Debate wrote Skinner back to ask, "Unlike the car analogy, each person needs the fullest available (or "luxury") complement of valves functioning perfectly for the longest period of time, doesn't he?"

Skinner's response: "No — every treatment has side effects and risks, and not everyone wants Maserati healthcare — I don't want it (again because of the risks and side-effects)."

Skinner did ultimately write in a follow-on email exchange, "What the Mayo Clinic does — I'll define that as gold-standard care. And that's cheap."

What remains entirely unproven is whether the *replication* of Mayo Clinic quality care for a general population that is itself differently situated from Mayo's patients and deals with health care providers differently situated from Mayo itself would be nearly as "cheap."

Henry Aaron, a senior fellow at the Brookings Institution, listed some commonly cited procedures such as electrocardiograms and spinal surgery. Vivian Ho, a health economist at the Baker Institute at Rice University and an associate professor at the Baylor College of Medicine, also mentioned back surgery and added antibiotics that are prescribed for upper respiratory diseases, and knee replacements — all of which are well documented as being overused.

But both acknowledged that, in many cases, all of those procedures are extremely beneficial. "It's very hard to think of any service in common use that doesn't in some cases provide very high benefits," Ho said.

Aaron has advocated, in particular, for the "Cadillac tax," which the Center for Medicare and Medicaid Services has estimated will reduce total health care costs modestly when it goes into effect in 2018. But when asked whether he is sure that all of the procedures that will be forgone because of the policy will have been wasteful, Aaron acknowledged that he was not.

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Most proponents of squeezing utilization interviewed by Remapping Debate acknowledged that underutilization was a significant problem, and that most policies — like the Cadillac tax — aimed at reducing overutilization did nothing to address it.

When asked whether he believed that most Americans were receiving enough health care, Jonathan Gruber, an economist at the Massachusetts Institute of Technology and one of the leading champions of the Cadillac tax, said "Of course millions of people would benefit from more care."

Though he said that it was important to focus on the lack of access to health care that is experienced by people with no insurance coverage, Gruber said that underutilization is "the wrong issue." The "right issue" to focus on, he claimed, is overutilization.

In several interviews with proponents of reducing utilization, it became clear that they were beginning from an assumption that reducing utilization is an imperative because reducing costs is an imperative.

Remapping Debate asked the advocates of reducing utilization whether a better starting point might be an evaluation of what it would take to move all Americans to the highest possible level of care, an assessment that would allow for open and transparent decisions as to the extent that we as a society should pay for such care or deny such care.

When asked why that wasn't her preferred course, Rice's Vivian Ho said, "Because we're spending too much money right now."

Tracy Miller, an associate professor of economics at Grove City College, acknowledged that that path might mean less immediate risk to patient health, but said that the increased spending necessary to achieve it would require either reduced spending in other areas or tax increases.

When asked whether Americans might tolerate an increase in taxes if what they would be getting — improved health care — was clearly apparent to them, Miller said that they might. But when asked whether he was in favor of taking such a path, he said, "Obviously it's a matter of priorities, but in my personal view, we're spending too much tax revenue on health care as it is."

A different starting point?

J. Sanford Schwartz, a professor of medicine and health care management at the Wharton School of the University of Pennsylvania, told Remapping Debate that the continuing focus on reducing the amount of care conceals the fact that we are actually making choices about what kinds of care we want to provide, and that those choices have consequences.

> "The vast majority of what people call overutilization is care that involves tradeoffs between costs and benefits," said J. Sanford Schwarts of the Wharton School. "The conversation we should be having about those services is whether we're prepared to pay the cost to get the benefits. That's different from saying, 'We're doing too much, let's cut back.'"

"The vast majority of what people call overutilization is care that involves tradeoffs between costs and benefits," he said. "The conversation we should be having about those services is whether we're prepared to pay the cost to get the benefits. That's different from saying, 'We're doing too much, let's cut back.'"

That sentiment was echoed by several of the physicians interviewed for this article. "I think there are a lot of people out there who have an agenda to cut healthcare costs," said Daniel Barocas of Vanderbilt University. "Before we do that, I think we need to have an honest conversation about what kind of healthcare system we want in this country, and that isn't what has been happening."

Arthur MacEwan, a professor emeritus of economics at the University of Massachusetts Boston, said that we would be in a better position to have that conversation if instead of beginning from the assumption that we're spending too much money on healthcare, we began by asking what it would take to get the highest possible quality of care to the greatest number of people.

If providing such "Cadillac" or "gold-standard" care to everyone is "going to cost more than we can afford," MacEwan said, "then maybe we have to do less, but at least we would be making conscious, informed decisions."

Don McCanne, a family practitioner and senior health policy fellow at Physicians for a National Health Program, a group that advocates for a single-payer health system, agreed and added that from that perspective, the gap between the care that Americans currently get and what would be considered a "gold standard" of care could well become a matter of more urgency than the costs.

"If we were looking at it that way," McCanne said, "I think the first thing we might see is that there are millions of people who are not getting the care they need right here and right now."

Additional reporting by Craig Gurian.

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