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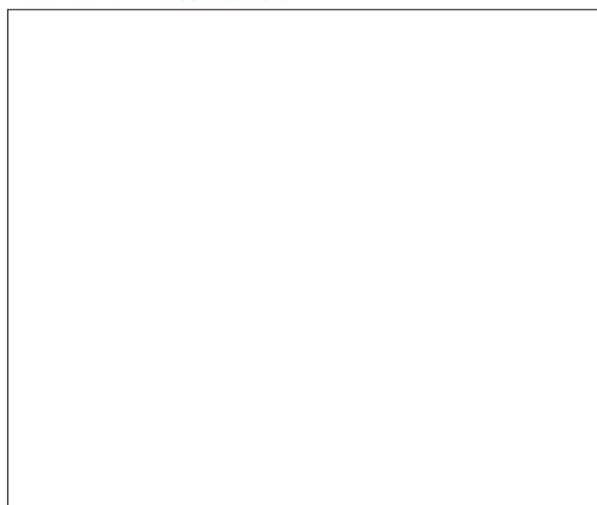
Decision Makers Differ on How To Mend Broken Health System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Nowhere else in the world is so much money spent with such poor results.

On that point there is rare unanimity among Washington decision makers: The U.S. health system needs a major overhaul.

For more than a decade, researchers have documented the inequities, shortcomings, waste and even dangers in the hodgepodge of uncoordinated medical services that consume nearly one-fifth of the nation's economy. Exorbitant medical bills thrust too many families into bankruptcy, hinder the global competitiveness of U.S. companies and threaten the government's long-term solvency.

But the consensus breaks down on the question of how best to create a coordinated, high-performing, evidence-based system that provides the right care at the right time to the right people.

During eight years in office, President George W. Bush took an incremental approach, adding prescription drug benefits to the Medicare program for seniors and the disabled and expanding the number of community clinics nationwide. President Obama, like the last Democrat to occupy the White House, contends that was insufficient and is pushing for an ambitious reworking of the entire $2.3 trillion system.

Framed by President Bill Clinton 16 years ago as a moral imperative to deliver health care to all, this summer's historic debate comes against a more urgent backdrop. As the national unemployment rate nears 10 percent and giants such as General Motors crumble, the expensive, inefficient health system has deepened the country's economic woes.

By virtually every measure, the situation has worsened.

Today, about 46 million Americans have no health insurance, so they go without or wait in emergency rooms for expensive, belated care. Everyone else helps pay for that Band-Aid fix in the form of higher taxes and an extra $1,000 a year in insurance premiums.

Pockets of medical excellence dot the landscape, but at least 100,000 people die each year from infections they acquired in the hospital, while 1.5 million are harmed by medication errors. Of 37 industrialized nations, the United States ranks 29th in infant mortality and among the world's worst on measures such as obesity, heart disease and preventable deaths.

Bright young physicians trained at prestigious and expensive universities enter a profession built on perverse financial rewards. They, like assembly-line workers of the past, are paid on a piecemeal basis, earning more money not by doing better but simply by doing more.

Yet more care rarely translates into better health. Extensive research by Dartmouth College has found the

exact opposite: Health outcomes are often best in communities that spend less compared with cities such as Boston and Miami where the medical arms race of specialists and high-tech gadgets often leads to greater risks and injuries.

The Institute of Medicine estimates that one-third of all medical care is pure waste, such as duplicate X-rays, repeat lab tests and procedures to fix mistakes.

"Most Americans don't understand how bad health care in the United States is," said Michael F. Cannon, head of health policy at the libertarian Cato Institute. "We need big reforms."

Across the ideological spectrum, the diagnosis is remarkably consistent.

"Sure, some people here have the best health care in the world, but the average American is paying too much and not getting enough in return," said John D. Podesta, who led Obama's transition team and heads the Center for American Progress, a think tank.

Said Sen. Judd Gregg (R-N.H.): "What's tragic is that so much of this spending is on duplicative or unnecessary care that doesn't improve health outcomes."

Simply put, the goal of health reform is to finally get our money's worth, say industry leaders, policymakers, consumers and business executives.

They envision a health-care system that guarantees a basic level of care for everyone, shifts the emphasis to wellness and prevention, minimizes errors, and reduces unnecessary and unproved treatment. Such a system would coordinate care, track patients and doctor performance electronically, and reward good results. The high-value system of the future would be organized "so that people get the care they need and need the care they get," said Elizabeth A. McGlynn, associate director of the health research division of Rand Corp.

Nowadays, that is often not the case.

On average, Americans receive the recommended, proven care 55 percent of the time, according to Rand studies. Sometimes, doctors or nurses overlook a basic but critical step, such as prescribing a beta blocker medication to patients after a heart attack, a therapy shown to significantly reduce the risk of a fatal attack. At other times, patients undergo procedures when there is no evidence that they are any better than a simpler, cheaper alternative.

Ten years ago, in its landmark report "To Err is Human," the Institute of Medicine estimated that 44,000 to 98,000 people die each year from medical mistakes, highlighting the need for improvement. Since then, the tally has risen, said Janet Corrigan, president of the National Quality Forum, a nonprofit membership organization that promotes quality standards.

"We now know estimates of those who die from hospital-acquired infections is upwards of 100,000," she said. "Many of those, if not most, are avoidable and preventable."

Sen. Robert C. Byrd's recent hospital stay, for example, has been extended because the West Virginia Democrat developed a staph infection.

"Everyone agrees that hospitals are hazardous to your health," said Mitchell Seltzer, a consultant who advises large medical institutions. "For every day a patient is in a bed, they are subjected to a higher probability of medical errors, hospital-acquired infections, inappropriate tests that do not have a direct bearing on the medical condition being treated."

Part of the problem is cultural, said Rand's McGlynn.

"People tend to demand the new thing even if there's not much evidence it will make a difference in the length or quality of life," she said.

Few patients or physicians have any idea who delivers good, or bad, care, because few organizations track results. Consumers have more information to evaluate their cars than they do their surgeons.

"It's like a doctor flying the plane without instruments," said James N. Weinstein, a spine surgeon who directs the Dartmouth Institute for Health Policy and Clinical Practice.

Obama set aside $19 billion in his economic stimulus package to promote the use of digital records, on the belief that they reduce duplication, produce more consistent care and cut down on errors.

Because the fee-for-service payment system rewards quantity over quality, there is little incentive -- and there are even disincentives -- for doctors, nurses and hospitals to improve, Corrigan said.

"Is it a surprise we have lots of extra imaging tests and lab tests?" she said. "Not at all."

The consequences are especially glaring in regions with larger numbers of specialists and pricey technology, the Dartmouth data show.

Take the case of Miami vs. La Crosse, Wis. In 2006, using inflation-adjusted figures, Medicare spent $5,812 on the average beneficiary in La Crosse, compared with $16,351 in Miami. Yet an examination of health status in both places, adjusted for age, finds no evidence that the extra spending resulted in better care, Weinstein said.

"That's the enigma here," he said. "Less is more, and more isn't better."

Physician behavior and spending patterns in Medicare have been good indicators of broader trends across the nation, Dartmouth has found.

Even the best physicians cannot stay current with all of the drugs, tests and treatments available today -- another reason to digitize modern medicine, Corrigan said.

Many fear that the push to contain costs will result in rationing.

In today's system, "we don't ration care, we ration people," said Donald M. Berwick, president of the independent Massachusetts-based Institute for Healthcare Improvement. "We know that if you are black and poor or a woman, there are all sorts of effective interventions you are not going to get."

Though the transition would be painful and the politics treacherous, Berwick said it is possible to spend less on medical care and have a healthier nation.

"If we could just become La Crosse, think of how much better off we would be," he said.

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