

What a Texas town can teach us about health care

Atul Gawande wrote a long article for the New Yorker Magazine. This document condenses some of the highlights from that article.

McAllen versus El Paso Texas

- McAllen Texas is one of the most expensive health-care markets in the country. In 2006, Medicare spent fifteen thousand dollars per enrollee here, almost twice the national average.
- El Paso County, eight hundred miles up the border, has essentially the same demographics. Yet in 2006 Medicare expenditures in El Paso were \$7,504 per enrollee half as much as in McAllen.
- And yet there's no evidence that the treatments and technologies available at McAllen are better than those found elsewhere in the country.
- The annual reports that hospitals file with Medicare show that those in McAllen and El Paso offer comparable technologies.
- Public statistics show no difference in the supply of doctors. Hidalgo County actually has fewer specialists than the national average.
- Nor does the care given in McAllen stand out for its quality. Medicare ranks hospitals on twenty-five metrics of care. On all but two of these, McAllen's five largest hospitals performed worse, on average, than El Paso's.
- Something fundamental had changed since the days when health-care costs in McAllen were the same as those in El Paso and elsewhere.

McAllen overuse of medicine

- Compared with patients in El Paso and nationwide, patients in McAllen got more of pretty much everything more diagnostic testing, more hospital treatment, more surgery, more home care.
- Between 2001 and 2005, critically ill Medicare patients received almost fifty per cent more specialist visits in McAllen than in El Paso.
- In 2005 and 2006, patients in McAllen received
 - 20% more abdominal ultrasounds,
 - 30% more bone-density studies,
 - 60% more stress tests
 - 200% more nerve-conduction studies
 - 550% more urine-flow studies

- And Medicare paid for five times as many home-nurses visits.

- **The primary cause of McAllen's extreme costs was, very simply, the across-the-board overuse of medicine.**

More Quantity does not mean more Quality

- Americans like to believe that, with most things, more is better. But research suggests that where medicine is concerned it may actually be worse.
- In fact, the four states with the highest levels of spending Louisiana, Texas, California, and Florida were near the bottom of the national rankings on the quality of patient care.
- That's because **nothing in medicine is without risks**. Complications can arise from hospital stays, medications, procedures, and tests, and when these things are of marginal value the harm can be greater than the benefits.
- **In 2006, doctors performed at least sixty million surgical procedures, one for every five Americans.** No other country does anything like as many operations on its citizens.
- **Some hundred thousand people die each year from complications of surgery far more than die in car crashes.**
- Patients in high-cost areas were actually less likely to receive low-cost preventive services, faced longer waits at doctor and emergency-room visits, and were less likely to have a primary-care physician.
- **They got more of the stuff that cost more, but not more of what they needed.**

Some places get it right

- Most Americans would be delighted to have the quality of care found in places like Rochester, Minnesota, or Seattle, Washington, or Durham, North Carolina all of which have world-class hospitals and costs that fall below the national average.
- **If we brought the cost curve in the expensive places down to their level, Medicare's problems (for the next fifty years) would be solved.**
- Health-care costs ultimately arise from the accumulation of individual decisions doctors make

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about which services and treatments to write an order for.

- The most expensive piece of medical equipment, as the saying goes, is a doctor's pen. As a rule, hospital executives don't own the pen caps. Doctors do.
- Why do [doctors respond] so differently from one place to another?
- It turned out that differences in decision-making emerged in only some kinds of cases. In situations in which the right thing to do was well established made the same decisions.
- But, in cases in which the science was unclear, some physicians pursued the maximum possible amount of testing and procedures; some pursued the minimum. And which kind of doctor they were depended on where they came from.
- In case after uncertain case, more was not necessarily better. But physicians from the most expensive cities did the most expensive things.

Medical Schools are not Business Schools

- No one teaches you how to think about money in medical school or residency. Yet, from the moment you start practicing, you must think about it.
- Beyond the basics, however, many physicians are remarkably oblivious to the financial implications of their decisions. They see their patients. They make their recommendations. They send out the bills.
- Others think of the money as a means of improving what they do.
- Then there are the physicians who see their practice primarily as a revenue stream. They figure out ways to increase their high-margin work and decrease their low-margin work. This is a business, after all.
- In every community, you'll find a mixture of these views among physicians, but one or another tends to predominate.
- The anchor tenants [at shopping centers] that set norms encouraging the free flow of ideas and collaboration, even with competitors, produced enduringly successful communities, while those that mainly sought to dominate did not.
- [Possibly] anchor tenants play a similarly powerful community role in other areas of economics, too, and health care may be no exception.

- About fifteen years ago, it seems, something began to change in McAllen. **A few leaders of local institutions took profit growth to be a legitimate ethic in the practice of medicine.** Not all the doctors accepted this. But they failed to discourage those who did.

Medicine first, team approach

- Mayo Clinic is among the highest-quality, lowest-cost health-care systems in the country. Among the things that stand out was how much time the doctors spent with patients.
- There was no churn no shuttling patients in and out of rooms while the doctor bounces from one to the other. Most of the patients, required about twenty minutes.
- The core tenet of the Mayo Clinic is **The needs of the patient come first not the convenience of the doctors, not their revenues.**
- But decades ago Mayo recognized that the first thing it needed to do was eliminate the financial barriers.
- It pooled all the money the doctors and the hospital system received and began paying everyone a salary, so that the doctors goal in patient care couldn't be increasing their income.
- Mayo promoted leaders who focused first on what was best for patients, and then on how to make this financially possible.
- **The aim is to raise quality and to help doctors and other staff members work as a team. But, almost by happenstance, the result has been lower costs.**
- The Mayo Clinic is not an aberration. One of the lowest-cost markets in the country is Grand Junction, Colorado, that nonetheless has achieved some of Medicare's highest quality-of-care scores.
- Years ago the doctors agreed among themselves to a system that paid them a similar fee whether they saw Medicare, Medicaid, or private-insurance patients, so that there would be little incentive to cherry-pick patients.
- They also agreed, to meet regularly on small peer-review committees to go over their patient charts together. They focused on rooting out problems like poor prevention practices, unnecessary back

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operations, and unusual hospital-complication rates. Problems went down. Quality went up.

- The leading doctors and the hospital system adopted measures to blunt harmful financial incentives, and they took collective responsibility for improving the sum total of patient care.

Someone has to be accountable for total care

- The question we have to ask is whether the doctor is set up to meet the needs of the patient, first and foremost, or to maximize revenue.
- There is no insurance system that will make the two aims match perfectly. But having a system that does so much to misalign them has proved disastrous. As economists have often pointed out, **we pay doctors for quantity, not quality.**
- As they point out less often, **we also pay them as individuals, rather than as members of a team** working together for their patients. **Both practices have made for serious problems.**
- The lesson of the high-quality, low-cost communities is that someone has to be accountable for the totality of care. Otherwise, you get a system that has no brakes. You get McAllen.
- Expanding public-insurance programs like Medicare and shrinking the role of insurance companies will not make much difference. [Neither will expanding insurance companies role.]
- The use medical savings accounts and hold high-deductible insurance policies will not work. Who is going to haggle price for a surgery? Any plan that relies on the sheep to negotiate with the wolves is doomed to failure.
- **Providers have to be weaned away from their untenably fragmented, quantity-driven systems of health care, step by step.**
- And that will **mean rewarding doctors and hospitals**, in which doctors collaborate to increase prevention and the quality of care, while discouraging overtreatment, under treatment, and sheer profiteering.
- Under one approach, insurers whether public or private would allow clinicians **who formed such organizations and met quality goals to keep half the savings they generate.**
- Government could also shift regulatory burdens, and even malpractice liability, from the doctors to the organization. **Other, sterner, approaches would penalize those who don't form these organizations.**
- Congress has provided vital funding for research that compares the effectiveness of different treatments, and this should help reduce uncertainty about which treatments are best.
- But we also need to fund research that compares the effectiveness of different systems of care to reduce our uncertainty about which systems work best for communities. These are empirical, not ideological, questions.
- And we would do well to form a national institute for health-care delivery, bringing together clinicians, hospitals, insurers, employers, and citizens to assess, regularly, the quality and the cost of our care, review the strategies that produce good results, and make clear recommendations for local systems.
- **Dramatic improvements and savings will take at least a decade. But a choice must be made.**
- Whom do we want in charge of managing the full complexity of medical care? We can turn to insurers (whether public or private), which have proved repeatedly that they can't do it.
- Or we can turn to the local medical communities, which have proved that they can.
- But we have to choose someone because, in much of the country, no one is in charge. And the result is the most wasteful and the least sustainable health-care system in the world.
- In the war over the culture of medicine the war over whether our country's anchor model will be Mayo or McAllen the Mayo model is losing.
- We face a decision that is more important than whether we have a public-insurance option, more important than whether we will have a single-payer system in the long run or a mixture of public and private insurance, as we do now.
- **The decision is whether we are going to reward the leaders who are trying to build a new generation of Mayos and Grand Junctions. If we don't, McAllen ... will be our future.**