

# U.S. 'Not Getting What We Pay For'

## Many Experts Say Health-Care System Inefficient, Wasteful

By Ceci Connolly - [http://www.washingtonpost.com/wp-dyn/content/article/2008/11/29/AR2008112901025\\_pf.html](http://www.washingtonpost.com/wp-dyn/content/article/2008/11/29/AR2008112901025_pf.html)

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Talk to the chief executives of America's preeminent health-care institutions, and you might be surprised by what you hear: When it comes to medical care, the United States isn't getting its money's worth. Not even close.

"We're not getting what we pay for," says Denis Cortese, president and chief executive of the Mayo Clinic. "It's just that simple."

"Our health-care system is fraught with waste," says Gary Kaplan, chairman of Seattle's cutting-edge Virginia Mason Medical Center. As much as half of the \$2.3 trillion spent today does nothing to improve health, he says.

Not only is American health care inefficient and wasteful, says Kaiser Permanente chief executive George Halvorson, much of it is dangerous.

Those harsh assessments illustrate the enormity of the challenge that awaits President-elect Barack Obama, who campaigned on the promise to trim the average American family's health-care bill by \$2,500 a year. Delivering on that pledge will not be easy, particularly at a time when the economic picture continues to worsen.

Senate Finance Committee Chairman Max Baucus (D-Mont.) has already warned that improving and expanding health care will cost money in the short run -- money that his Republican counterpart, Sen. Charles E. Grassley (Iowa), argues the government does not have.

Yet among physicians, insurers, academics and corporate executives from across the ideological spectrum, there is remarkably broad consensus on what ought to be done.

A high-performance 21st-century health system, they say, must revolve around the central goal of paying for results. That will entail managing chronic illnesses better, adopting electronic medical records, coordinating care, researching what treatments work best, realigning financial incentives to reward success, encouraging prevention strategies and, most daunting but perhaps most important, saying no to expensive, unproven therapies.

"There is more than enough money in the system," said former House speaker Newt Gingrich, who runs the District-based Center for Health Transformation. "We just are not spending it well."

The United States today devotes 16 percent of its gross domestic product to medical care, more per capita than any other nation in the world. Yet numerous measures indicate the country lags in overall health: It ranks 29th in infant mortality, 48th in life expectancy and 19th out of 19 industrialized nations in preventable deaths.

One way to reconfigure health spending is to shift large sums into prevention and wellness, said Reed Tuckson, a physician and executive vice president at UnitedHealth Group in Minneapolis. The idea is to tackle the handful of preventable, chronic illnesses such as heart disease and diabetes that account for 75 percent of health-care costs.

Each year, for example, the United States spends \$450 billion treating heart and artery disease. The "good news," Tuckson said, is that former certain killers such as heart attacks, strokes and aneurysms can now be treated. But the price -- of maintenance drugs, ongoing tests and procedures such as stents -- is high. It would be wiser, he argued, to attack underlying problems such as smoking, diabetes, high cholesterol and high blood pressure.

Since Obama's victory, official Washington has been racing to demonstrate its seriousness about expanding health coverage to every American, while at the same time improving the quality of care. But few of the politicians talk about the difficult tradeoffs that will come with any real reform, said Kaplan in Seattle, whose health system follows Toyota's quality-control model.

One fundamental problem is how doctors are paid, he said. Under the current fee-for-service scheme, "the more you do, the more you make," Kaplan said. There is no incentive to keep people out of doctors' offices, hospitals, imaging centers and dialysis clinics.

More tests lead to more procedures, which often result in mistakes, complications, misdiagnoses or the use of untested therapies, said Donald Berwick, president of the Institute for Healthcare Improvement in Cambridge, Mass. "The current system is very hospital-centric," he said. "We wait for people to get sick, and then we invest enormous sums to fix them up. We should build primary care as the core."

It is possible to change the incentives, Kaplan said. Partnering with Starbucks and the insurer Aetna, Virginia Mason devised a new strategy for dealing with back pain, the leading medical complaint of Starbucks' coffee-pouring baristas. Virginia Mason made big money on MRIs, but there is little scientific data that the scans resolve the problem.

So they flipped the process, trying physical therapy first. To make up for some of Virginia Mason's lost revenue, Aetna increased its payment for the therapy. Today, the majority of Starbucks employees with back trouble return to work within 48 hours without an MRI or a prescription, Kaplan said.

"We've shown that you can have superior outcomes at lower costs," Kaplan bragged. He acknowledged, however, that the success on back pain is "one small vignette" in a mega-mess.

Moving from pricey, high-tech solutions such as MRIs to older, low-tech approaches such as physical therapy requires solid data and a culture change, said Helen Darling, president of the National Business Group on Health, which represents large employers. Americans are attracted to innovations, regardless of cost or whether they have been proven to achieve results.

A whole-body scan that is covered by insurance may seem like a bargain, Darling said. "But one way or another we're all paying" for it in higher premiums, increased government expenditures and even false-positive results that lead to more costly, invasive procedures.

The members of Darling's group are in the vanguard of a movement toward comparative effectiveness research, which evaluates various drugs, devices and treatments and publicizes which work best and at what cost. Ideally, doctors and patients armed with that data could make more rational decisions -- such as whether to choose a more expensive, but therapeutically equivalent, medication.

Former Senator Thomas A. Daschle, Obama's choice to head the Department of Health and Human Services, endorsed the use of comparative effectiveness data in a book he co-authored.

Better data may also address what Dartmouth College researchers describe as large, "unwarranted" variations in medical spending. Analyzing Medicare payments for patients in the final two years of life, the school's Institute for Health Policy and Clinical Practice found that similar care -- when adjusted for differences in age, race and diagnoses -- cost as much as \$93,000 at the UCLA Medical Center and as little as \$55,000 at the Mayo and Cleveland clinics. The national average was nearly \$53,000.

With those sorts of variations, the Dartmouth team concluded that as much as 30 percent of medical spending -- or \$700 billion -- does nothing to improve care.

Even if only a third of that could be invested in critical programs, "imagine the possibilities," said Peter Orszag, head of the Congressional Budget Office, who was nominated last week to be director of the Office of Management and Budget in the Obama administration. "Given the scale of it, I am puzzled as to why we are not doing more to improve the efficiency of the health system."