

Study: Unneeded procedures inflate health care costs

By Jake Miller and Keith Uhlig
Wausau Daily Herald
November 29, 2009

You wouldn't buy a second car when one would do. Nor an extra airplane ticket when you're traveling solo.

But if your son topples from his skateboard and breaks an arm, you probably don't think twice about paying for an X-ray in the emergency room – and a second X-ray a day later when he sees a sports-medicine specialist.

That, in a nutshell, is a key reason the cost of health care is so high: We pay vast sums for duplicative procedures. In fact, the Dartmouth Atlas of Health Care estimates that 30 percent of medical procedures are redundant, a staggering figure, considering that the Centers for Medicare & Medicaid Services projects the health care industry to account for almost 18 percent of the nation's gross domestic product by the end of this year.

Although there's no agreement on how to eliminate redundancy in health care, consensus has formed around the reasons for it.

- The traditional way we pay for health care, called fee-for-service, provides a financial incentive for physicians and other providers to order lots of procedures.
- Medical records aren't easily shared, with the result that one doctor doesn't always know what treatment another has prescribed for the same patient, leading to duplicated procedures.
- Patients, their heads chock-full of information gleaned from Web sites and television ads, demand more, new and better treatments from their doctors.

Redundancy is a key issue for many advocates of health reform because the volume of procedures is so closely tied to the cost of care. And those costs only continue to grow.

This year, national spending on health care is expected to increase by 5.5 percent, according to a projection by the Centers of Medicare and Medicaid Services, following a 6.1 percent increase in 2008. Altogether, more than \$2.4 trillion was spent on health care in 2008, the agency estimates.

Curbing the number of procedures could save billions.

Making changes

The health reform legislation approved earlier this month by the U.S. House of Representatives contains a provision requiring the Institute of Medicine to conduct a detailed, multiyear study to determine the precise number and type of procedures that constitute the best treatment for a variety of ailments – the idea being to weed out procedures that don't make a patient any healthier.

Case in point: Marshfield Clinic, which saved \$48 million in a three-year federal study in which it cut procedure that failed to improve the health of patients with conditions such as heart failure and diabetes.

Cutting duplicative procedures is easier said than done, as long as doctors and others are paid for every service they provide. It's a simple equation: More procedures equal more income. For physicians with high overhead costs, survival is at stake.

"There's any awful lot of stuff that gets done in medicine," said Brent Miller, the Washington-based lobbyist for Marshfield Clinic. "Not by (large group practices) but by doctors who are trying to make ends meet."

Chris Queram, president of the Wisconsin Collaborative for Healthcare Quality, an organization of hospital, physician and insurance industry groups seeking to improve the quality and cost-effectiveness of health care in the state, called the present method of reimbursement "toxic."

"We need to shift away from this fee-for-service scheme and reimburse actual outcomes," Queram said. Translation: Payment ought to be based on what course of treatment actually makes a patient better – not on the volume of procedures that make up the treatment.

Talk, please

An additional key to wiping out redundancy is making certain that physicians and other health professionals are on the same page when treating the same patients. That means ensuring that all providers have quick access to each patient's medical records.

That's the way it works now within the Aspirus, Ministry Healthcare and Marshfield Clinic networks, the major health care providers in central Wisconsin.

Those laptops doctors carry around? They provide access to results of any medical procedures performed within that particular network. If a doctor is curious about your cholesterol level, he or she can check the results of your last test with a couple of mouse clicks. No need to order another test.

Trouble is, records aren't shared between competing institutions. Besides, in much of the country – and particularly in small, independent medical practices – doctors don't use electronic records.

And that's a challenge. Without access to medical records from other facilities, it's easy for doctors to justify the cost of additional procedures to patients, Miller said.

Change might be coming, however.

Making it easier

The economic stimulus package enacted into law earlier this year set aside \$2 billion for development of a health information exchange – essentially a huge data bank that would consolidate records from all over the country, reducing administrative costs and redundancy. In addition, financial incentives totaling \$34 million were allocated for health care organizations that use electronic records to improve care by 2014.

Closer to home, the state Department of Health Services is working with Wisconsin health institutions to develop a statewide database.

"We'd be doing better in controlling our health care costs nationwide if it looked somewhat like Wisconsin," state Health Services Secretary Karen Timberlake said. "But we still have work to do here."

Our fault?

We patients deserve some of the blame for the sheer volume of medical procedures and prescriptions, too.

Although the Internet has created a class of better-informed consumers, it's more and more common for a patient to arrive at the doctor's office after scouring the Web, convinced he knows what ails him – and what the doctor should do about it. Others request specific drugs based on TV ads and grow angry when doctors turn them down.

Such demands can lead to additional, unnecessary costs.

Dr. Larry Gordon, an Aspirus internist, said the proliferation of medical information on the Internet can undercut patients' trust in their physicians.

One patient in whom he diagnosed diabetes refused to believe him, based on information she had picked up online. She sought two more opinions and ran up additional bills only to have Gordon's diagnosis confirmed.

"I have had people come in and say this is the medicine they need," Gordon said. "And most of the time, it's not what they need."

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