Dynamic Chiropractic

PATIENT EDUCATION

How Doctors Have Ruined Health Care

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About 35% of all surgical deaths and 50% of postoperative complications, such as infection, are probably preventable. As many as one-fourth of all patients who die in hospitals may have been misdiagnosed by physicians. Up to 35% of all hospital admissions are not needed. Some 15% to 30% of diagnostic tests don't help or aren't even looked at. Those shocking figures come from a study conducted by a bipartisan group backed by major corporations, headed by former Presidents Ford and Carter, and staffed by some of the brightest minds in the medical business today. (The data, culled from medical research and expert testimony are contained in a confidential memo from the staff to the National Leadership Commission on Health Care members.)

Studies published in medical journals tend to confirm these findings. They report, for example, that 44% of bypass surgeries are unwarranted or questionable. For cardiac pacemaker implants, 20% of procedures are not necessary and another 36% ambiguous. And the California-based think tank, Rand Corp., found that in one particular surgical procedure, carotid endarterectomies -- the delicate procedure surgeons perform to clear the major neck artery to prevent strokes -- 32% were done, if not capriciously, then without much justification.

"One-fourth of hospital days, one-fourth of procedures and two-fifths of medications could be done without," wrote Rand fellow Dr. Robert Brook in a recent article in the Journal of the American Medical Association. "Almost every study that has seriously looked for hospital overuse has found it, and virtually every time at least double-digit overuse has been found."

A truly astonishing percentage of the $650 billion annually spent on health care in this country is wasted; the result of unnecessary surgery, unneeded diagnostic procedures and puffed-up bills. The incidence of operating room incompetence is chilling.

Even the average layman is beginning to learn about the overuse of common procedures such as hysterectomies and cesarean sections. (By the time they reach 70, about two-thirds of the women in the U.S. have had their uterus removed.)

What is causing this outrageous medical overkill? A biased reward system has a lot to do with it. Says Mark Banks, medical director and head of quality control at Blue Cross/Blue Shield of Minnesota's HMO: "We have a historic inequity that favors procedural processes. We pay the doers more than the thinkers."

Americans also seek instant gratification when it comes to new medical technology. Bank goes on: "Americans have an appetite for consuming high-tech health care. But there isn't evaluation of the new technology. Lots of evaluation is done in real time with real dollars."

Meanwhile, the cost of American health care continues to soar. We will spend $650 billion in 1990, about 12% of GNP. Growing at today's double-digit annual clip, health care will suck up 15% of GNP by the year 2,000. Already the U.S. spends more on health care per person than France and West Germany, and nearly twice as much as Britain (see table).

And if you think we get more for our money, think again. Infant mortality and life expectancy

statistics -- indicators of just how good our medical system is -- lag behind Japan, England, Canada, West Germany, and Sweden.

Why is the system out of control? Certainly not for lack of corrective initiatives. Private insurance companies and the government have taken steps to cut costs and increase competition. Diagnostic-related groupings (DRGs), imposed by Medicare, limit payment for procedures so that hospitals have an incentive to hold down costs. In November, congress made an attempt to corral doctor's fees by, among other things, limiting payments for expensive diagnostic tests that could have been done the less-expensive, old-fashioned way -- by physical examination. Insurance companies and employers are pushing cost sharing. But most of these initiatives have backfired. "Faced with efforts to hold down costs, doctors have responded partly by increasing services. And doctors do control demand, much more so than the patient. Even with the freezes, income from Medicare to doctors increased 31% from 1980 to 1986," reported the National Health Care Campaign, a coalition of religious, charitable and union groups.

Ed Morton, chief operating officer of Health Care, Inc., a Naples, Florida-based diversified health care provider, also puts much of the blame on physicians and the physician-dominated health care system: "You can't have these guys running around like the Lone Ranger. You think Ollie North was a loose cannon? You think the loss of S&L oversight caused problems? Without appropriate and timely review, you put yourself in a position where abuse can take place."

That can happen at outpatient surgery centers as well, especially when doctors own a piece of the action. Ford Motor, which spends $1.02 billion a year in employee medical benefits, refuses to reimburse patients for facility charges done in outpatient centers not affiliated with a hospital. Why? Because there isn't sufficient scrutiny as to whether surgery is necessary.

Nor is the much-vaunted second opinion the panacea it was supposed to be. Medical politics and fear of malpractice suits make most doctors unwilling to openly contradict a peer.

Political problems aren't limited to doctors, of course. While studies show that hospitals specializing in a particular procedure do it better -- a sort of practice-makes-perfect effect -- most are reluctant to give up any department, even an underutilized one, for fear of losing prestige or physician support.

And the controls are inadequate to begin with. A recent study by the Joint Commission on Accreditation of health care organizations (JCAHO) revealed that more than a third of the 5,200 hospitals it surveyed lacked the sort of controls necessary to guard against inappropriate surgery, unnecessary blood transfusions, and/or uncoordinated treatment of intensive-care patients.

"It's a major challenge to convince any organization in the delivery of service that quality is important and at the same time cost-effective," says Dennis O'Leary, president of the JCAHO. "Generally speaking, American industry is ahead of the hospital field, well ahead, in applying quality improvement techniques."

Former Surgeon General C. Everett Koop wrote shortly before leaving office in October: "We have a system that is distinguished by a virtual absence of self-regulation on the part of those who provide care -- hospitals and health care workers, primarily physicians -- but distinguished as well by the absence of such natural marketplace controls as competition in regard to price, quality or service."

What all this means, for starters, is that there is a tremendous need for medical information. At present, a doctor tells the patient what surgery is needed and where to have it done. There is no

way for a patient to participate in the process by judging cost or quality factors. If an employee's health care plan points to a specific hospital, he has no way to check that the lower-cost provider is doing high-quality work. It's like having a ford dealer tell you how many cars your family needs and where to buy them, too.

"If we don't have quality-of-care procedures in place, or quality assurance systems, such as exist in other industries, we're going to make a lot of mistakes, waste a lot of money and hurt a lot of people." says Dr. Henry Simmons, head of the National Leadership Commission on health care.

In Washington, there's growing talk of nationalizing health care to curb runaway costs and provide for the 37 million Americans with no health coverage at all. The proposals run the gamut from granting tax breaks, to encourage citizens to buy their own insurance, to forcing employers to provide basic coverage for workers.

The plans have one thing in common: They deal with the symptoms -- exploding costs and the uninsured -- without addressing the disease. We are still far from knowing which parts of the American medical system are worth saving and which should be discarded.

"We've got all the computers we need to analyze the data," says Representative Fortney "Pete" Stark (D-Cal.). "It's a crime more isn't being done. We've got 21st-century equipment but 19th-century procedures for looking at the data."

Here's what the government needs to do to generate the information the public badly needs.

Spend a lot more for research. Washington has to get into the business of gathering and disseminating information to the public. In the area of technology, for example, less than 1% of the federal government's $108 billion health care budget goes to figuring out the best and most cost-effective way to use the hundreds of high-tech products that flood the medical field every year.

Set standards for medical care to stop surgical and diagnostic overuse. Think about it: The FDA demands that each new drug be subjected to rigorous testing, but less than 20% of the nation's medical procedures are put to any review, according to the Office of Technology Assessment (OTA). The Leadership Commission's Simmons estimates that a $500 million effort would be enough to study the most commonly performed procedures and come up with guidelines. Some doctors deride practice guidelines as "cookbook" medicine and worry that substandard physicians might be tempted to simply follow the recipe regardless of a particular patient's needs. But the American Medical Association and others are working vigorously to develop quality checklists that could at least provide a patient and doctor with an outline of options. And the savings could be enormous: up to $22 billion a year if there was only a 5% reduction in unnecessary surgery for 11 of the most commonly performed operations. And that doesn't even count savings from overused diagnostic tests.

Start a national data bank that would contain information about doctors -- including disciplinary action -- and hospitals, with cost and quality measures. Measuring "quality" isn't easy. The JCAHO, which accredits hospitals, is just now developing statistical measurements to evaluate a hospital's treatment record, such as whether there's a high postsurgical infection rate. The government should use the JCAHO guidelines to do the same for the public. That may mean more hospitals will go out of business. But that may not be a bad thing: Beds today are still only about 60% occupied. In a 1988 report, OTA advised setting up a "consumer affairs" agency within the department of Health and Human Services to begin the process of providing information to patients.

The special interest groups -- doctors, hospitals, and even the insurers -- all agree on the need for

health care reform in general and more quality information in particular. But that's where the harmony ends and the back-biting begins.

"I hear lots of slogans and can imagine the placards about the proper structure of health care reform, but I don't hear many people out there saying, 'Yes, we are willing to forgo some of our income for the public good,'" says William Roper, President Bush's domestic policy adviser. Roper indicates that Bush won't make health care reform a priority unless and until some sort of consensus is reached by the big boys: The American Medical Association, the American Hospital Association and the insurance lobbies.

Good luck.

The mighty AMA, a big source of congressional campaign money, has never been wild about giving the public access to date on doctors. HHS, for example, has a new data bank that will keep a national scorecard of such things as disciplinary actions and malpractice awards against the nation's 500,000 physicians. The data bank is supposed to help hospitals and other health care agencies check a physician's background. At present, a doctor may get into trouble in one state and set up shop in another, with little danger his poor record will follow him. But largely because of AMA objections, the national data bank can't be tapped by the general public. The new doctor in town may have a blacklist 50 pages long, but there will be no way for his patients to find out.

And hospitals aren't any better. Three years ago, when the Health care Financing Administration, which administers Medicare, began publishing data on hospital mortality rates, the hue and cry from the nation's health care providers was deafening. The idea behind HCFA's data was to help doctors and patients make decisions about where to go for care. If Bob Smith was about to go in for, say, heart surgery, a quick review of local hospitals would show which institution had the best record of success, or at least the lowest level of ultimate failure: patient deaths.

The AHA says the data is so misleading it's of little benefit to patients. True, the data isn't properly indexed for severity of illness at admission. But consumer groups argue that even less-than-perfect information is better than no information at all. And HCFA's mortality data, as limited as it is, has given the industry a strong incentive to develop data the public can understand.

"It's simply not acceptable to say that because the data is imperfect, we'll do nothing," says Bush aide Roper, who, as HCFA's former chief, first released mortality data for public scrutiny. "There's too much at stake to sit on our hands until something better comes along."

There are other signs the government is edging in the right direction. In the 1990 budget, congress allocated $32 million -- up from $5 million the previous year -- for studies on the effectiveness of four extremely common ailments for which surgical solutions are now being questioned: heart attacks, lower back pain, cataracts, and prostate problems. Says administrator Norm Weisman of the National Center for Health services, a subsidiary of HHS: "What we are trying to do is determine what outcomes there are so we can say to physicians and to patients, 'Here are the risks and here are the benefits.'"

One of the problems in setting policy, according to Dr. David Eddy, a Duke University specialist, is that up until now the analysts and policymakers have assured that the scientific base of medicine was solid.

Eddy believes that premise is just plain wrong. "The wide variation in using procedures points to a soft intellectual basis," he comments. Eddy, who has degrees in both surgical medicine and mathematics, designs statistical models that assess just how well certain procedures really work.

"Outcomes research" like Eddy's poses a fundamental question: Are doctors practicing a kind of ritualistic medicine, not unlike the barber/doctors who did bloodletting in the Middle Ages?

Eddy believes doctors tend to use familiar homilies like a "stitch in time saves nine" or "an error of commission is to be preferred to an error of omission: "Most of the simplifications and heuristics point in one direction, toward overutilization. When this happens the price is paid in terms of inconvenience, pain, distress, days in the hospital, unnecessary risks, and money."

It may be ignorance rather than greed that leads to medical overkill. Many patients who are dissatisfied simply move on to a new doctor and never complain. Since complete medical records are only available for Medicare patients over 65, it is difficult for a doctor to get proper feedback.

While many organizations laud Eddy's work -- he has been a consultant for Chrysler, Blue Cross/Blue Shield, HMOs and the AMA -- some of his findings have caused a furor. Take his work on Pap smears. For 40 years, the American Cancer Society promoted the annual Pap smear to detect cervical cancer early. Then, Eddy's statistical analysis showed the test to be virtually as effective for screening cancer when given every three years. The ACS changed its recommendations, provoking a storm of controversy from the American College of Obstetricians and Gynecologists.

Eddy's work on outcomes is supplemented by the so-called "small area studies" of Dr. John Wenneberg, a Dartmouth University medical professor. Using Medicare data, Wennberg discovered striking variations in the rates for certain surgical procedures from one community to another. In his landmark prostatectomy studies for the state of Maine, Wennberg not only found large regional variations in the number of surgeries used to treat benign urinary tract obstructions common in older men, but also that the risk of complications from the surgery was far higher than generally believed. Thanks to Wennberg's highly publicized research, there are now 35% fewer prostatectomies done in Maine.

Wennberg's studies have demonstrated that knowledge leads to more conservative practice.

What all this suggests is that the biggest problem with health care isn't cost, it's waste. Eliminating that waste would save the nation untold billions, but how can that be done? Chiefly, by gathering the information and disseminating it to the consuming public, who have a right to know. And how can reluctant congressmen and senators be goaded into action? Through the mailbox.

The "Show-Me" Days Are Here

With corporate health care costs up another 9% this year to over $150 billion, more firms are taking a closer look at what they're getting for their money. Just last month, Georgia-Pacific raised its deductible from $200 to $300 and began charging $600 per employee per year for family coverage, up from $400. In some cases this has led to labor strife. Nynex and Bell Atlantic both underwent four-month strikes this year when they tried to institute larger health insurance co-payments.

A group of around 20 major corporations including Alcoa, Hewlett-Packard, General Electric, Ford, and Honeywell have pioneered in trying to hold down unnecessary health care costs. "As companies kept complaining about rising costs, we began to hear from the providers: 'All you care about is costs; you don't care about quality,'" says Alcoa benefits manager Dick Wardrop. "So we said: 'Okay, tell us about quality.' We got silence. So we concluded: 'Either they know and they are keeping quiet for a reason or they don't know.'"

Compounding the silence were biting articles by Dr. Arnold Relman, editor of the New England

Journal of Medicine, arguing that 20% to 30% of medical procedures are inappropriate. Equally damning were studies showing surprisingly high variations in medical practices from one region to another. Gradually, says Wardrop, this "led large companies to realize that this is one of the reasons the Japanese are eating our lunch." Ford, for example, spends $305 per automobile on health care costs, 50% more than their Japanese counterparts.

Dr. John Burns, an internist and kidney specialist, is Honeywell's vice president of health management. Burns believes that industry has gone through three phases in its attempts to cut health costs. First, it promoted health maintenance organizations. Firms hoped HMOs could shift the risk to a provider to cut costs. But, says Burns, a process of "adverse selection" emerged with younger and healthier employees joining the HMOs, and older, sicker ones not joining them. That sabotaged the initiative.

Second, firms asked employees to shoulder larger deductibles or co-payments. The hope was that this would give employees incentive to be more selective.

Finally, companies resorted to utilization agents who limit financial exposure by imposing a maximum payment per diagnosis, or by limiting the length of a patient's hospital stay.

But the last two "solutions" proved to be flops, as well. "None of the above has resulted in any significant cost savings. Nothing has dented the system," says Burns. Why? The answer, he claims, is that the focus has been on attempting to control costs through benefit design without describing what is necessary and appropriate health care.

"Now," says Burns, "we are saying that, if in retrospect they can determine cases not to be necessary, why can't we design a system where criteria are known, published and communicated? The answer," he asserts, "is that we can." In private conversation, says Burns, physicians will admit much of what they do is neither necessary nor appropriate. His conclusion: "The payment system incentivizes extra medicine."

The solution, then, he continues, is to go directly to a group of physicians and say, "We will reward you by sending you more patients so that it will increase your market share, provided the standards of the medical literature are the determinant of the process." With $160 million in health payments last year, Honeywell has the clout to talk like that.

Burns says he goes to the medical director of a physician group or hospital and says: "We are interested in purchasing standard-based health care. Show me, department by department, what quality improvements you have instituted. What standards do you have for coronary artery surgery? Do you have a high-risk pregnancy program designed to minimize the incidence of premature birth? Some groups do. They may have data to show that their premature birthrate is 50% lower than the state average. And guess what? It is cheaper. And that is the new paradigm. The shift from cost control to quality control through health management." S.R.

The Prototype

One interesting prototype of a national health information network can be found in Pennsylvania. Each of the keystone state's 290 medical institutions is being ranked quarterly on how well it treats a variety of medical conditions, and how much it charges for them.

This one-of-a-kind consumer guide to hospitals is still in the development stage but the state has high hopes its new Health Care Cost Containment Council, which publishes the information, will boost competition to help curb Pennsylvania's skyrocketing health care budget, now at $2 billion.

"We are trying to get good, reliable, consistent information that people can use to buy health care," says Council Director Ernie Sessa. "By disseminating this information we hope to create a truly competitive marketplace in health care."

The first trial run report, published in June, compared mortality rates and medical complications for 55 different conditions -- from lower back pain to heart failure -- at 15 south central Pennsylvania hospitals. What the consumer guide shows quite clearly is how much treatment and cost can vary from one facility to another. The average charge for hip and knee replacement at Lancaster Community Hospital, for example, was $7,300 while at nearby Hershey Medical the charge reached $12,500.

Pennsylvania's paying dearly to foster competition. The Health Care Cost Containment Council's annual budget is $2 million. On top of that, the hospitals had to lay out up to $200,000 to purchase computer systems.

And Pennsylvania's initiative is proving highly controversial. There have been complaints that the computerized screening program wasn't designed for hospital comparisons. Health care experts say there are inconsistencies in how hospitals report the data, which may not accurately reflect how sick patients were upon admission, for example.

"No one knows whether what it's measuring is an accurate indicator of quality of care," says Dr. Norbert Goldfield, a New Englander who has written a book about the issue. He says the best indicator of a hospital's quality is probably patient satisfaction, but the data collected in Pennsylvania doesn't include that human factor.

Director Sessa agrees that Pennsylvania's methodology isn't perfect but says it's a first step in providing the sort of comparative data that will enable employers and patients to seek out high-quality, low-priced care. Besides, he doesn't expect miracles. "Our goal is to hold down the escalation of the cost of health care to at least somewhere around the consumer price index level."

The next step: a similar type of consumer guide rating physicians. L.C.

Finding a Good Doctor

Most people find a doctor by asking family and friends. "It's better than nothing," says Dr. Lynn Soffer of the Public Citizen's Health Research Group in Washington, D.C. "But it really overemphasizes the personal, rather than technical, attributes of a physician.

How else is the average person supposed to pick a doctor? "Find out where and when they graduated from college," says Soffer. "Are they board-certified in a recognized specialty?" And how does one go about doing that? "One way is to look at the walls in their offices," she replies. "Another way is to consult the Directory of Medical Specialists at the library. To do that, you need to know the city where the doctor is practicing medicine or the city where he completed his residency.

"If you're moving to a new city," she continues, "call the head of the department at a medical school or university hospital in the area and ask for a recommendation. That will help your chances of getting a good doctor, one who keeps up with the latest medical procedures."

The Office of Technology Assessment, congress' investigative arm, published a report in 1988, entitled The Quality of Medical Care -- Information for Consumers, notes that "Formal disciplinary actions by the state medical boards provide the most valid information about poor-quality physicians." Unfortunately, such information is simply not available to the general public. "It would

be nice if you could get information like whether a doctor has ever been disciplined or how often he has been sued," says Soffer. "But unfortunately, that's a big secret."

You can get some useful information about hospitals, however. The OTA recommends that patients review hospital mortality rates, published by the Health Care Finance Administration (HCFA). Another indicator is the volumn-outcome relationship for a specific operation. Research shows that the more often a specific operation is performed at a hospital, the higher the success rate. If you already know what type of illness you have, there are often specialized data banks on physicians or hospitals. For instance, the National Cancer Institute has introduced a data base called PDQ that combines updated information on cancer treatment, research protocols, and physicians and organizations involved in cancer care. PDQ can be accessed by anyone who has a personal computer and a standard telephone line.

Within PDQ, a directory provides the names, addresses and telephone numbers of more than 14,000 individual physicians who spend a major portion of their clinical practice in the care of cancer patients. Another PDQ directory lists approximately 1,600 health care organizations with cancer treatment programs.

For more information, you can call 1-800-4-CANCER. In addition to PDQ, NCI will provide general information about various types of cancer treatments and locations of clinical trials research in the caller's regional area.

You can also call organizations like the American College of Obstetricians and Gynecology, or the American Society of Plastic and Reconstructive Surgery for information on an illness or operation. The latter, for instance, will provide a caller with the names of 10 board-certified plastic surgeons in a specific region, as well as educational brochures and background on a particular doctor. The background check is cursory, however. H.H.

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