Reprinted from THE WALL STREET JOURNAL.

MONDAY, DECEMBER 22, 2003

Who Gets Health Care? Rationing in an Age of Rising Costs

Dose of Prevention: Six Prescriptions To Ease Rationing In U.S. Health Care

Getting Wired; Using Research; Changing Pay; Managing Disease; Fixing ICUs

Patient: Educate Thyself

By Laura Landro

[Last in a series]

Scanning a bank of video screens, Joseph Cooke zoomed in on one elderly patient lying in an intensive-care unit across the street. Dr. Cooke gave the man a quick visual exam. Then he checked the vital signs on the computer, looking for any change in blood pressure, heart rate or oxygen levels that might signal an impending cardiac arrest or life-threatening infection.

From his remote command post, Dr. Cooke watches three units on different floors at one hospital. That could help solve a massive nationwide problem: With a shortage of ICU specialists, patients aren't well-enough monitored, leaving them vulnerable to complications that lead to longer hospital stays and force hospitals to ration beds. At the New York-Presbyterian Healthcare System, where Dr. Cooke works, two new "eICU" stations cover six units in two different hospitals, and plans call for an expansion into all 30 of its hospitals.

Slowly, the drive to improve quality and efficiency that has swept through corporations is starting to arrive at the famously inefficient world of hospitals. Across the country, rising costs have forced some hospitals to effectively ration services, making life-and-death choices about who gets care and who goes without. But by boosting efficiency, cutting waste and medical error, and sticking to treatments that demonstrably work, medical experts are finding that many harsh decisions about who gets care might not have to be made in the first place. The new strategies range from installing high-tech systems that replace doctors' scribbled notes to simple practices, such as making sure that patients' beds are properly tilted so infections don't set in.

The crusade to bring the quality movement to hospitals, pushed in the past mainly by nonprofit groups, is now starting to get a boost from Medicare and powerful employer groups. Today, the federal Department of Health and Human Services plans to release the first national report on the quality of health care in America, which is expected to acknowledge gaps in key areas such as preventive care and chronic-disease care, and endorse many of the solutions quality experts propose for fixing them.

"We need to take back the money that goes into waste and harm in the system and make it an ethical imperative to free it up for the things that really add value," says Margaret O'Kane, president of the National Committee for Quality Assurance, a nonprofit group that accredits about half of the nation's managed-care organizations.

How big could the savings be? Donald M. Berwick, chairman of the Boston-based nonprofit Institute for Healthcare Improvement, estimates the U.S. could cut 15% to 30% of its $1.4 trillion annual health-care tab by operating more efficiently and improving quality. David Wennberg, director of the Center for Outcomes Research and Evaluation at Maine Medical Center, says Medicare could trim 30% of its $285 billion budget, by bringing the highest-spending regions of the U.S. in line with the lowest. A study published by Dr. Wennberg and a group of colleagues this year found that Medicare enrollees in higher-spending regions receive more care than those in lower-spending regions but don't have better health outcomes or satisfaction with care.

Adopting information technology could save $125 billion just by eliminating unnecessary paperwork, according to research by the Markle Foundation. Eliminating medical errors would save $37.6 billion, says the National Academy of Science's Institute of Medicine. Reducing the overuse of just three antibiotics would have a big impact: $1 billion in potential savings, according to VHA Inc., an alliance of 2,200 nonprofit hospitals across the country, including the Mayo Clinic and Cedars-Sinai.

Some rationing is here to stay, given America's appetite for health care and an aging population that will need more of it. That will require facing tough issues, such as whether it is justified to pay millions of dollars to keep a few patients alive if those same dollars could keep hundreds more healthy. But by redirecting money spent on unnecessary or ineffective care, and improving the quality of care, it's possible to have a system of "rational" rationing.

"We know that not everyone gets the health-care services they need, but more problematically, too many people get services they do not need," says David Dranove, a professor at Northwestern University's Kellogg School of Management and author of a recent book on rationing.

Hospitals are now experimenting with new ways to achieve rational rationing. Here are six of the most promising ideas:

Wiring the Health System

Many medication mistakes are caused by illegible prescriptions and decimal point errors. As many as 20% of such preventable mistakes are life threatening, says the Leapfrog Group, a coalition of major employers trying to cut health-care costs.

One medication mistake, the group says, adds more than $2,000 to the cost of hospitalization. That translates to $2 billion per year nationwide. Using comput-

erized order entry -- electronic prescribing systems that avoid handwritten errors -- can make a huge difference. Boston's Brigham and Women's Hospital, a pioneer in the use of such systems, reduced error rates by 55% over eight months. Rates of serious medication errors fell by 88% over a four-year period in a subsequent study.

Technology can give hospitals a better handle on what's working. St. Luke's Hospital, the largest hospital in the Kansas City area, is investing about 4% of its operating budget in information systems, compared with an average of 2.5% in the industry. It uses an electronic data system to track 58 measures of quality, such as how many patients are re-admitted or have to return to the operating room. Units get "balanced scorecards" to see areas where things are going well and where they need to improve.

Group Health Cooperative in Seattle, one of the largest managed-care nonprofit health plans in the country, recently spent more than $40 million on a clinical information system for its 560,000 members. The system manages patient records, delivers lab results online, automatically refills prescriptions and checks for possible drug interactions. "On the day it turned on across the state of Washington, 9,000 pieces of paper stopped flowing around the system," says Ted Eytan, associate medical director for clinical informatics.

Evidence-Based Medicine

As much as half of the care provided to Americans is unnecessary, including procedures that don't do any good, tests that are repeated, and drugs for which there is no evidence of benefit, according to studies cited by a 2001 report of the National Institute of Medicine, a government advisory group.

Meanwhile, patients often don't receive the care that evidence shows is effective. Between 17% and 32% of surgeries performed on Medicare patients are unnecessary, according to Dr. Wennberg, the outcomes researcher. A survey by Rand Corp., a think tank in Santa Monica, Calif., says patients only receive recommended care about half of the time, noting a "tremendous gap between what we know works and what patients are actually getting." For example, national data show that less than 25% of people with hypertension have it under control with recommended blood-pressure medications.

One way to close that gap is "evidence-based medicine": insisting that a doctor's opinion is backed by published evidence of a treatment's effectiveness. After using its electronic records to identify people at risk for heart attacks, Group Health will soon start 11,000 previously untreated patients on cholesterol-lowering drugs called statins. It based the move on evidence of the effectiveness of statins in the Heart Protection study, a five-year trial of more than 20,000 patients. The decision "will cost us $700,000 per year we didn't budget for," says Vice President Peter Adler, "but it will improve the wellness of our patients and is likely to save us $5 million in the long run."

Another opportunity to save money is to eliminate the overuse of antibiotics, which account for 15% to 20% of the average hospital drug budget. Overuse has caused resistance to many antibiotics, leading to more medical complications and costs.

A study of 11 hospitals by VHA found that three common antibiotics used in patients with kidney failure or urinary-tract infections were overused or unnecessarily used, based on clinical guidelines for their conditions. By using lower doses or less-expensive drugs, the average 250-bed hospital found savings of $100,000 annually -- which indicates more than $1 billion could be saved nationwide in all hospitals, says VHA Vice President John Hitt, who oversaw the study.

Money saved could be redirected into proven care, Dr. Hitt says. "If I could take the money I was spending on excess drugs used after surgery and give everyone a beta blocker after a heart attack, it would be ideal," says Dr. Hitt. While hospitals have been improving the rate at which they prescribe beta-blocker drugs after a heart attack to prevent a second one, for example, as many as 30% of patients still don't get them.

But more research needs to be done. The budget for the federal Agency for Healthcare Research and Quality is less than 0.2% of total health-care spending, which is "grossly insufficient," researchers at the Commonwealth Fund said last month. The nonprofit foundation proposed a new federal agency to set national priorities for quality and develop standards of care, much as federal highway standards helped improve auto safety. The Institute of Medicine proposes a $1 billion "innovation fund" to improve quality and safety.

Fixing Reimbursement

The biggest barrier to improving care, many say, is a reimbursement system that doesn't factor in quality and actually rewards waste.

(MORE)

"No wonder our health-care system is so screwed up -- the best hospital in town and the worst hospital in town get paid exactly the same thing for a heart bypass or a hip replacement," says Tom Scully, who just stepped down as director of the Centers for Medicare and Medicaid Services. "There is no other part of our economy besides health care where you have zero economic penalty for being inefficient."

Since doctors and hospitals are paid only for procedures and treatment they provide, they are actually penalized if they eliminate unnecessary procedures or practice preventive care. Doctors get paid to perform heart surgery and treat patients in the hospital but not to care for heart patients so that they avoid hospitalization.

That's starting to change. Medicare is offering incentives for doctors in pilot programs who adopt information technology and practice preventive medicine, and boosting payments to hospitals that report publicly on the quality of their care. A Medicare spokesman said the aim is to fix quality problems and cut costs in the long run. Employer groups including the Pacific Business Group on Health and the General Electric Co.-led "Bridges to Excellence" program are offering doctors incentives to provide preventive care for chronic diseases, including diabetes. But such efforts will have to be more widely adopted by big insurers before they make a dent.

The Bridges to Excellence program, which includes self-insured health plans run by Ford Motor Co., UPS, Procter & Gamble Co. and Verizon Communications Inc., just doled out its first payment to doctors in a pilot program in Louisville and Cincinnati. Doctors receive bonuses of $100 per patient for keeping patients' blood pressure, blood sugars and other diabetes measures under control.

"We are creating an incentive for the fundamental re-engineering of processes and outcomes in physician's offices," says Francois de Brantes, program leader for GE's corporate health-care initiatives. But if the effort stays limited to self-insured purchasers, he says, it won't be enough to spur real change. "The barrier we haven't been able to overcome is getting health plans to fully participate."

Health plans have been wary about paying doctors for preventive practices, because they aren't yet sure of how that

would work on a large scale or how results would be measured. Some argue that doctors should be providing such care anyway.

Disease Management

Many experts agree the best opportunity to improve care and stave off costly complications is disease management -- the strategy of monitoring people with chronic conditions such as diabetes, congestive heart failure and coronary artery disease. Those diseases are expected to cost $510 billion this year and soar to $1.07 trillion by the 2020. But many of those costs are related to preventable hospitalizations and emergency-room visits.

For years, studies have shown that getting patients into disease- management programs can avoid many of those problems. Disease management closely monitors a patient's status on a regular basis. A growing number of companies, under contract with Medicaid or other insurers, now keep tabs on patients.

At nonprofit Care South Carolina, which serves 27,000 mostly low- income patients, an electronic recordkeeping system monitors patients with diabetes closely and ensures that they see doctors for regular foot exams to watch for sores that might lead to amputations. Chief Executive Ann Lewis says the center hospitalizes its patients less frequently than others in the state -- and those hospital stays are for less serious and less costly problems. The average payment Medicaid has to make for their hospitalizations is $3,545, compared with $10,894 for diabetes patients in other programs in the state, she says.

Better preventive care can dramatically reduce hospitalization for congestive heart failure, a chronic ailment marked by progressive weakening of the heart's pumping strength. Yet standards are all over the map in the U.S. Among Medicare patients, about one-third of those with the disease haven't had the most important test to assess the function of the part of the heart that makes it pump efficiently. About one-third don't have a prescription for the blood pressure medication known as an ACE-inhibitor used to treat the disease. Half of the patients hospitalized with congestive heart failure are readmitted within six months.

But numerous studies show marked improvement if patients take the right medication and are closely monitored. Such care can reduce hospital costs by more than 30% and cut rehospitalizations in half, studies show.

Florida's Medicaid program, for example, contracted with a company called Lifemasters to manage thousands of residents with congestive heart failure. Patients can check in by phone or Web site, and nurses monitor vital signs and symptoms to identify potential problems. Beneficiaries get digital scales and electronic blood-pressure cuffs, and even phones to call in if they need them. Lifemasters gets in touch with doctors directly if a problem arises. Patients in the program spent an average of 38 fewer days in the hospital, and the state cut the cost of its Medicaid program by 6% in the first two years after paying the fees for the program.

Redesigning the ICU

The sickest 1% of patients -- the chronically ill and those in the ICU -- account for 27% of all health-care costs. Intensive care eats up $180 billion annually, much of that on care that has little effect on survival and isn't wanted by terminally ill patients anyway, studies show. "Most people when dying want the comfort and care of being surrounded by family, not the torture of all sorts of tubes in every orifice you have," says Dr. Wennberg, the outcomes researcher.

But many complications that lead to unnecessary deaths and longer stays could be prevented with ICU redesign programs, including new technology such as the eICU, even if they cost money in the short- term. A few years ago, at six hospitals run by Sentara Healthcare in Virginia, ICU doctors were stretched. "We didn't have enough ICU beds, we had a harder time holding on to ICU nurses and the care was just inconsistent," says Rodney Hochman, chief medical officer and CEO of Sentara's Norfolk General Hospital.

Two of Sentara's hospitals were the first to use an eICU, a system designed by former intensive-care specialists who launched software maker Visicu Inc. These systems are operating or being installed at a total of 17 hospital groups, covering about 60 ICUs. By electronically monitoring more patients, improving quality controls and adhering to strict guidelines about which patients should be in the unit, Dr. Hochman says two of his hospitals reduced ICU mortality rates, adjusted by the severity of patient illness, 27%, and cut hospital costs for ICU patients 25% over the last two years.

A study to be published next month in the journal Critical Care Medicine says the eICU system has shortened the length of stays in four of the Sentara ICUs by 17% and allowed the ICU to handle 15% more cases. Sentara says the $2 million it spent to buy the software and get it up and running has already paid for itself with $3.5 million in saved costs and new revenue.

By using resources efficiently, Dr. Hochman says the hospital may be able to avoid "having to decide between one patient and another."

Improving hospitals' practices can make a big difference in the ICU as well. VHA, the nonprofit hospital alliance, is sponsoring a "Transforming the ICU" program that has trained 20 ICU teams to follow simple guidelines that are often ignored, such as correctly adjusting the tilt of the bed of a patient on a ventilator to prevent pneumonia, and stopping the use of antibiotics that might cause further complications. Merely improving care of patients on ventilators has saved 47 lives and $3 million in an average ICU with 1,000 admissions annually, VHA says.

VHA says in the first year of the program, the collective length of stay in the ICU was reduced from nearly 2.5 days to 1.1 days, which means the ICU can accept 654 more patients. Together, two hospitals in the program saved nearly 5,000 patient days and $5.3 million in one year. Surgical-infection prevention programs, being conducted with the Centers for Disease Control and Medicare have also saved millions of dollars in ICU and surgical units.

Getting Patients Involved

The final barrier: the patients. Most consumers aren't actively engaged in their care or "prepared to make judgments about treatment alternatives based on evidence," says Paul H. Keckley, executive director of Vanderbilt University's Center for Evidence-based Medicine. "We have lulled consumers to be dependent on physicians."

But after years of being conditioned to expect that medical care comes at little cost, Americans are being asked to dig deeper into their own pocket -- which may make them think twice about which care has value, and what is unnecessary. Everyone, including consumers, will need to make more informed choices about which medical services are most beneficial, says Paul B. Ginsburg, president of the Center for Studying Health System Change. "If we are to cover everyone, we can't cover everything."

Big Losses

Estimated lives and costs that could be saved each year by delivering recommended care

PROGRAM: Controlling high blood pressure
DEATHS: 28,300
HOSPITAL COSTS* (in millions): $1,243
PROGRAM: Diabetes care-HbAlc control
DEATHS: 13,600
HOSPITAL COSTS* (in millions): $178.5
PROGRAM: Smoking cessation
DEATHS: 2,700
HOSPITAL COSTS* (in millions): $97.7
PROGRAM: Cholesterol management
DEATHS: 6,500
HOSPITAL COSTS* (in millions): $94.2
* Due to heart attacks and stroke
Source: National Committee for Quality Assurance