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Doctors, Dollars & Quality

PREFACE: Does the United States have enough doctors, given the enormous demand for health care and forecasts about a future filled with aging and chronically ill baby boomers? And do we have the right mix of doctors—since specialists “cost” more to produce than general practitioners, are paid more under current reimbursement systems, and prescribe more health care to boot?

These are complicated questions, as the following papers make clear—and the answers are based almost entirely on separate sets of statistical analyses. Let’s walk through the arguments pro and con—from those who contend we don’t have enough doctors, and from those who contend that what we need, both to save money and to improve health, is not more doctors overall but more general practitioners and fewer specialists.

■ How many doctors, and what kinds?
Both the size and the composition of the physician workforce might be expected to affect health outcomes. If you have enough doctors of the “right” type in a given community, it may seem reasonable to expect that people may be healthier. But, in fact, many studies indicate that it is hard to attribute any measure of health status directly to what doctors actually do to their patients. For example, all the doctors in the world might not be able to produce a healthy population in a community where poor and relatively uneducated people grow up next to toxic waste dumps.

■ Specialized training matters—or does it?
There is a closer connection to the quality of care provided by doctors, and that should affect the health outcomes of patients. If a doctor knows how to treat heart attack patients correctly, the odds are that more of his or her patients will survive. One might think that the more highly trained specialists, the more patient care would improve, but, paradoxically, the evidence doesn’t always show that.

For example, in an analysis published in Health Affairs in April 2004, Katherine Baicker and Amitabh Chandra compared data across states on health spending for Medicare beneficiaries, the physician workforce composition, and distinct measures of quality—such as whether heart attack patients were given aspirin within twenty-four hours of their admission to hospitals. They concluded that areas with a high concentration of specialists “also show higher spending and less use of high-quality, effective care” for Medicare beneficiaries. Their statistical analysis assumed that the total number of doctors was fixed—so that a high concentration of specialists automatically meant fewer general practitioners. They concluded that whatever might be the right total number of physicians, replacing specialists by family and general practitioners (FP/GPs) would both improve quality and lower costs.

 Needless to say, this view is controversial—and in this package of Health Affairs Web Exclusives, Richard Cooper attempts to disprove it. He uses the same classification of physicians and the same measures of overall quality that Baicker and Chandra used. However, he estimates the relationship to quality separately for the two types of doctors—generalists and specialists—instead of holding the total number of doctors constant. That leads him to assert that having all types of doctors improves the quality of health care delivered and, in particular, that “states with more specialists have better-quality health care.” When different authors estimate different relationships—substituting one kind of doctor for another, versus allowing for more doctors of both kinds—they get apparently contradictory conclusions.
Does Cooper’s analysis imply that we need more physicians generally in order to raise quality? Should we care, or not, about the balance between specialists and FP/GPs? In their Perspective reply to Cooper, Baicker and Chandra emphasize that the answer turns on whether the two different kinds of doctors have equal effects on quality. If it takes many more specialists to raise quality than it does a given number of FP/GPs, then composition clearly matters—and, they argue, increasing the number of generalists would be a more cost-effective approach to improving health care.

Does the level of overall health care spending produce better-quality care? Baicker and Chandra conclude that high spending is associated with low quality. But Cooper attacks their argument, using estimates of total health spending in each state, rather than the Medicare-only spending figures used by Baicker and Chandra. Cooper argues that using Medicare data alone produces a misleading picture, since the share of the population on Medicare, and Medicare’s percentage of overall health spending, vary from state to state. Using a broader measure of all health spending across states, including spending that isn’t directly related to patient care, Cooper finds that spending is positively related to state-level quality: higher total spending goes with better quality of care.

In their separate Health Affairs Perspective, Jonathan Skinner, Amitabh Chandra, David Goodman, and Elliott Fisher take up Cooper’s argument on this score and make two key points. First, changing the expenditure measure—that is, using figures of total state health spending, rather than just Medicare spending within the state—does nothing to contradict the various studies published earlier by Fisher, Baicker, and colleagues that have found negative results associated with increased Medicare spending. Second, they point out that even the “resourceful and imaginative researchers” at the Centers for Medicare and Medicaid Services (CMS), whose estimates Cooper uses, have not come up with a total measure of health care spending that truly reflects how individual health care services are used. In other words, “spending” can reflect prices, not just the volume of actual services, and unlike Medicare spending, it is sensitive to state-to-state differences in age distribution. These effects make it hard to see how spending translates into the quality of care that patients actually receive.

Where does this debate leave us? Both kinds of doctors provide care, and more of either kind can raise the quality as well as the amount of care delivered. If we didn’t care at all about costs, that would be all we needed to know. But specialists do cost more—no surprise there. So it matters whether their contribution to quality is enough greater than that of general practitioners to justify the extra cost.

When the question is asked this way—is specialists’ contribution to quality enough greater to justify the cost—the answer is no. If one uses the same set of quality indicators that all of these authors have used, having more specialists raises quality less per additional doctor than having more generalists does. Having too many specialists out of a given total number of doctors implies higher costs and lower quality of care.

On the separate question—whether we need more doctors, as Cooper asserts—these papers don’t settle the debate. But they do say clearly that we ought to care about what kind of doctors we train and hire, and that these choices will affect both the cost and the quality of health care.

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