**Variations In Medical Practice**

Citing the “great potential for substantial medical care cost savings” that would derive from more vigorous examination of the substantial variations which exist in medical practice patterns, Sen. William Proxmire of Wisconsin pledged at a public hearing to seek a greater federal investment in researching this phenomenon. Proxmire, the ranking Democrat on the Senate Appropriations Subcommittee on Labor and Health and Human Services, chaired a hearing November 19 at which witnesses representing a broad spectrum of health care interests testified. The lead witness was Dr. John E. Wennberg of Dartmouth Medical School, an epidemiologist who is regarded as the pioneer in researching small-area variations in medical practice patterns.

Wennberg discussed his proposal for dealing with the variations phenomenon, which he set out originally in the Summer 1984 issue of *Health Affairs*. In addition, Wennberg proposed that ½ of 1 percent of the Medicare Hospital Insurance Trust Fund be earmarked for studies of practice pattern variations to determine “what portion . . . is well spent and what represents unnecessary and even harmful uses of public resources.”

In spite of their different perspectives on health care delivery and financing, the witnesses generally agreed that more studies on practice variations were needed. Dr. James E. Davis of the American Medical Association supported Wennberg’s proposal in his testimony, saying, “We believe that [Wennberg's] activities are properly focused toward education and voluntary practice modification rather than intrusive governmental intervention.” He did, however, warn against taking “a centralized cookbook approach for standardizing medical practice based upon averages.”

Dr. Henry R. Desmarais, director of the Bureau of Eligibility, Reimbursement and Coverage, Health Care Financing Administration, concurred that “it appears that ‘practice style' accounts for large differences in use that may result in unnecessary or inappropriate care.” However, he cited current government efforts such as the peer review organization.
(PRO) program to control unnecessary care, and said he “would be uncomfortable” with Wennber's proposal to target government funds for further clinical outcome studies. Another witness, Dr. Thomas Dehn, vice-president of the American Peer Review Association, endorsed Wennberg’s proposal. “It is our hope that Congress will encourage the investment in medical care evaluation methodologies and in the potential for improving the quality and cost-effective delivery of medical care services available to all our citizens,” he said in his testimony.

Other witnesses who agreed that practice variations merit closer attention included John Marshall, director of the National Center for Health Services Research and Health Care Technology Assessment; Dr. Robert Gordon, special assistant to the director for research related to disease prevention, National Institutes of Health; Dr. John Bunker of Stanford University; Willis Goldbeck, president of the Washington Business Group on Health; and Charles Keyser of the American Psychiatric Association.

In his closing statement, Proxmire stressed his desire to make funding for practice variation studies part of the January budget: “This has been an extremely productive hearing. It has demonstrated that there is great potential for substantial medical care cost savings if we invest more of our time and resources in finding out what we are buying with our medical care dollars. I would hope this priority would be reflected in the President's January budget request. I will certainly do my best to see that this committee gives the practice pattern variations issue a high priority in making its funding decisions next year.”

**Variations In Massachusetts**

Another development in the study of practice variations is the recent release of a report on variations in surgical utilization in Massachusetts by the Health Planning Council for Greater Boston. This is the first such study to examine practice variations in an urban, industrialized state, Charles L. Donahue, Jr., executive director of the Health Planning Council, said in an interview.

**Methodology.** The Massachusetts study, conducted by Benjamin A. Barnes of the Harvard School of Public Health, and Elizabeth O'Brien and Charles Donahue of the Health Planning Council, observed variations among twenty-two surgical procedures using 1980 data collected by the Massachusetts Health Data Consortium. The consortium collects hospital discharge information from all Massachusetts hospitals and some from the bordering states. Only Massachusetts residents were included in the study, and the hospital data were adjusted according to the patients' residence. This methodology of analyzing rates by residence rather than by hospital is important in a state where there is substantial crossover by patients from one community to another to receive care. One hospital does not
always serve the needs for each individual community in which it exists.

For evaluations, the state was divided into forty-five groups with a minimum population of 55,000 people, and then into 172 subgroups with a minimum of 15,000 people. The study measured a variety of rates, including the rate of surgical activity for each subgroup, the distribution of surgery among various age groups, and the rate of variation for each of the twenty-two procedures.

Results, The results indicate that tonsillectomy, spinal fusion, pacemaker insertion, and excision of knee cartilage as the most variable procedures in Massachusetts, with tonsillectomy showing a fivefold variation among Massachusetts communities. The study measured a variety of rates, including the rate of surgical activity for each subgroup, the distribution of surgery among various age groups, and the rate of variation for each of the twenty-two procedures.

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that would curtail the high use rates of certain procedures and hospitalizations, and, to a lesser extent, result in the increase of low utilization rates where associated with inadequate care.”

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