The Need For Evidence-Based Health Policy To Address Health Care Variations

Until purchasers—including Medicare—seek value rather than price, solutions will remain elusive.

by Lynn Etheredge

ABSTRACT: Medicare policy making now deals mostly with price-setting issues. However, as Warren Buffet has noted: “Price is what you pay. Value is what you get.” Victor Fuchs’s studies raise fundamental issues for a value-oriented Medicare program. Florida offers one of many regional patterns of Medicare mortality that are not yet adequately explained. Valued-oriented, evidence-based Medicare policies would target opportunities to improve population health and would foster greater use of evidence-based medicine.

Victor Fuchs’s paper raises questions that are central to good public policy making for Medicare. Most of Medicare’s large area-to-area cost differences now result from variations in the number and mix of billed services. During the past thirty years several strategies have addressed Medicare geographic variations: peer review, nationally set payment rates (to replace payment amounts determined by providers), for-profit hospital payment reforms, and more fraud-and-abuse efforts (including a South Florida investigations office). With the Balanced Budget Act (BBA) of 1997, the idea of hiring private-sector managers, such as Medicare+Choice (M+C) health plans, gained political support; pending Medicare prescription drug legislation would add even more managed care options, such as preferred provider organizations (PPOs) and private drug plans. As Fuchs notes, there is prima facie evidence that Medicare’s providers and enrollees in South Florida stand out for producing and consuming much medical care.

Is managed care going to be the answer for Medicare’s high costs in South Florida, or in other areas? I would like to see Medicare managed care succeed—in terms of much higher quality than fee-for-service, better health outcomes, first-rate service, better benefits, lower costs, enthusiastic enrollees, and rapid growth rates. Alas, there is reason for skepticism about this. The unfortunate experiences of the M+C initiative are well known. South Florida enjoys its high-spending reputation while being an area with high M+C market penetration.

Fuchs’s recent studies and John Wennberg’s body of work, although differing in methods and findings, are useful guides for what can and cannot be explained, so far, about the Medicare data. Before I discuss how their evidence could be useful in shaping Medicare policies, however, it is essential to first consider the guiding objective. Most of the discussion about using managed care for Medicare, and as a national policy tool, has focused on the bottom line: saving the government money through eliminating “unnecessary” care and services. From my perspective, this guiding philosophy has been, and will continue to be, a prescription for modest success, in Medicare and nationally.

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In What Management Is, Joan Magretta goes to the heart of the matter when she writes that the purpose of business is the creation of value. Enterprises that fixate on their own bottom line will miss the path to long-run success. No value, no customers, no bottom line, no business. In the Medicare arena, the limited appeal of managed care to reduce use of services that patients and physicians believe have value was clarified for me, several years ago, when I asked my ninety-six-year-old grandmother why she didn’t join a health maintenance organization (HMO). “I have just one question,” she said. “Would the government want me to join an HMO so it could save money?” I said yes. “Well,” she said, “then I figure it’s not in my best interest.”

Too Much Spending Variation

Can national health policy produce value for Medicare’s enrollees in ways that could be translated into Medicare savings, in Florida and elsewhere? As I read the Fuchs and Wennberg analyses of Medicare spending variations, two opportunities stand out: (1) improve population health status; and (2) expand knowledge about, and use of, evidence-based medicine. National health policy, Medicare policy, and managed care that are committed primarily to achievement of these objectives could be guided by a philosophy for long-term success, well after the possibilities for easy, short-term profits are exhausted.

The work of Fuchs. Fuchs’s work highlights the importance of health status differences as an explanation for variations in Medicare spending. His work reminds us that health status for senior citizens, in Florida and nationally, is neither uniform nor fixed, but a wide-ranging variable influenced by many factors before and after a person reaches age sixty-five. His study with Mark McClellan and Jonathan Skinner of white Medicare enrollees ages 65–84 found that “the 10 percent of MSAs [metropolitan statistical areas] with the highest mortality...have an average death rate 38 percent greater than the 10 percent of MSAs with the lowest mortality.” Among the factors they find to explain differences in use are cigarette sales, obesity, and air pollution. There were also sizable variations among seven national geographic regions, including Florida, that remained unexplained.

Indeed, there are strong regional patterns for U.S. mortality rates from many conditions, as well as for the incidence of chronic diseases and their risk factors. The Web site of the U.S. Centers for Disease Control and Prevention (CDC) contains maps that illustrate such differences. National cancer statistics provide dramatic evidence of how a failure to deal with cigarette smoking has led to large rises in lung cancer mortality despite advances in biomedical research. In exploring South Florida’s better health status, Fuchs notes that there is evidence for the importance of physical activity and social life on senior citizens’ health.

In addition to Fuchs’s evidence, Healthy People 2010 offers a compendium of opportunities for improvements in health status. A new national strategy to improve health status would have many targets of opportunity. Much about regional variations in U.S. disease patterns, in Florida and nationwide, also remains unexplained. For example, Florida’s heart disease mortality for white women is highest in the northwest part of the state, whereas it is highest for black women in South Florida.

The work of Wennberg. Wennberg and his colleagues have used different methods and asked different questions of Medicare data. They consistently find very wide variations in health services use that are largely independent of patients’ needs and do not yield better outcomes. They also find that areas with higher Medicare spending do not make greater use of effective care. They have offered several well-reasoned Medicare policy proposals based on their work, in particular calling for shared patient-physician decision making and centers of medical excellence.

Possible Solutions

Diagnosis: underuse of evidence-based medicine and best practices. Prescription: greater use of evidence-based medicine and best practices. Those who have been pioneering this approach, in addition to Wennberg
and his colleagues, include the National Committee for Quality Assurance (NCQA), the Leapfrog Group, the Foundation for Accountability, Robert Brook, Don Berwick, Elizabeth McGlynn, the Pittsburgh Regional Health Initiative, the Jackson Hole Group, the Institute of Medicine (IOM), Minnesota’s Institute for Clinical Systems Improvement (ICSI), and the Agency for Healthcare Research and Quality (AHRQ). Minnesota, which has gone farthest in statewide commitment to evidence-based medicine (through ICSI), is among the lowest-spending Medicare states.

**Toward a national policy.** A national policy to develop this approach could include knowledge development, dissemination, and incentives. For knowledge development, a national “fast-track” research system could capture (online, in real time) the outcomes of millions of patients with different clinical treatments. For dissemination, physicians and patients could have desktop computer systems, built around electronic medical records, to bring the latest information, decision-making, and support technology to those who must make the important decisions about medical care. They could be supported by a new ICSI-type national organization with a mission to rapidly advance clinical practices based on evidence-based medicine and by a new generation of disease management initiatives, particularly for chronic disease. For incentives, Medicare and other payers should lead the way in paying for quality.

**Value, not price.** Most of Medicare’s policy making now deals with price setting. But price and value are different. As Warren Buffet has noted: “Price is what you pay. Value is what you get.” Fuchs’s Florida study, studies by Wennberg and colleagues, and related work are valuable in raising fundamental issues for a value-oriented Medicare program. There is more research to be done, and good ideas to try out. Let’s have evidence-based medicine—and evidence-based health policy.

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9. The Jackson Hole Group supports electronic medical records, for physicians and patients, and a national ICSI-type organization. Among groups working on the national health information infrastructure are the Markle Foundation and the Institute of Medicine.