

## EDITORIAL



## Medical Care — Is More Always Better?

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During the past decade, the Department of Veterans Affairs (VA) undertook a major reform of its health care system, one that is increasingly relevant as the United States confronts rapidly rising health care spending and persistent gaps in the quality of care. While the rest of the country moved toward less tightly structured delivery systems and unfettered access to specialists, the VA reform established 22 regional, integrated service-delivery networks, closed a substantial fraction of its hospital beds, and focused on ensuring access to high-quality primary care.<sup>1</sup> According to the VA Central Office, between 1994 and 1998 the number of veterans enrolled to receive VA care increased from 2.6 million to 3.1 million, and the number of hospital beds in use fell by 55 percent. The average veteran was receiving much less care — especially hospital-based care.

In this issue of the *Journal*, Ashton and colleagues evaluate the effect of this dramatic reduction in utilization on those most dependent on the hospital: patients with serious chronic disease.<sup>2</sup> They studied VA patients who were identified on the basis of an initial hospitalization for one of six medical conditions or three psychiatric conditions. Patients in each cohort were followed to assess their use of services and their survival during each year from 1994 through 1998. The findings were similar among the nine cohorts: hospital use declined by about 50 percent, medical clinic visits increased by about 10 percent, and visits for urgent care declined. A careful observer might worry about whether veterans sought care elsewhere, but an analysis of those over the age of 65 years found no compensatory increase in private-sector hospital use. In five of the cohorts, one-year survival rates improved significantly, whereas in the other four cohorts, the survival rates remained unchanged. The authors conclude that the reduction in hospital utilization was accomplished without serious adverse consequences.

Their cautious interpretation is appropriate, given the challenges inherent in drawing firm conclusions about causation from observational research. It is hard to disentangle the effects on survival of the reduction in hospital utilization from the other major changes in VA care that occurred during this period. Moreover, the composition of the cohorts may have changed in ways that the case-mix adjustment could conceivably have missed because of the dramatically decreased likelihood of admission during this period. If there was a bias, however, it seems likely that the cohorts in later years would have been sicker than those in earlier years, leading to an underestimate of the improvement in survival. It is possible, therefore, that the VA reforms led to improved survival: that less care was consistent with both better care<sup>3</sup> and better outcomes.<sup>2</sup>

This interpretation would be consistent with research that has explored the implications of regional variations in practice and spending. Twofold differences among regions in per capita Medicare spending have long been recognized. After adjustment for age, sex, and race, per capita Medicare spending in 2000 was \$10,550 in Manhattan, New York, for example, but only \$4,823 in Portland, Oregon.<sup>4</sup> The differences in spending are largely unrelated to differences in illness or price.<sup>5</sup> Rather, they are due to differences in patterns of practice, which are more inpatient-based and specialist-oriented in regions with high per capita expenditures.<sup>6</sup> As compared with similar enrollees in Portland, Medicare enrollees in Manhattan spent more than twice as much time in the hospital and had twice as many visits to physicians per year. During their last six months of life, Manhattan Medicare enrollees were three times as likely as Portland enrollees to spend a week or more in an intensive care unit and had five times as many visits to a medical specialist.<sup>4</sup>

Research shows that a high-intensity practice

pattern is associated with lower quality of care and worse outcomes than a more conservative practice pattern. States with high per capita Medicare spending provide lower quality of care.<sup>7</sup> Medicare enrollees in regions with high-intensity practice patterns have less access to care, have equivalent or worse satisfaction with care, and receive lower quality of care than those in regions with more conservative patterns.<sup>8,9</sup> For patients with hip fractures, colorectal cancer, or myocardial infarction, more conservative practice patterns are associated with better survival.<sup>8</sup>

The interpretation that the high-intensity practice patterns observed in many U.S. communities may be harmful (rather than simply wasteful) cannot be proved, but it should not be rejected out of hand.<sup>10</sup> The major differences in practice found between conservative and high-intensity regions lie in the number of physicians involved in a given patient's care, the number of minor tests performed, and the amount of time that otherwise similar patients spend in the hospital and intensive care unit. Discontinuity of care is harmful.<sup>11</sup> Diagnostic tests, when overused, can detect more pseudodisease and lead to more false positive results than would otherwise be found.<sup>12</sup> Hospitals are dangerous places, especially if you do not need to be there.

The possibility that the VA and the regions of the United States with more conservative practice patterns have it right (or at least better) suggests the potential for substantial savings. If all regions could safely adopt the practice patterns of the conservative regions, Medicare spending (and perhaps health care spending overall) would fall by about 30 percent.<sup>5</sup> But achieving such savings in the short term is most likely a practical and political impossibility (a third of the health care workforce would have to find new lines of work). A more realistic scenario is that by beginning to address the problem of overuse, we could improve quality, reduce harm, slow growth in spending, and free up resources to better meet the needs of those who are underserved.

But progress will require attention to three areas.<sup>6</sup> Two are familiar. First, current incentives must change, since they contribute to the overuse of discretionary services: most physicians, hospitals, and facilities are paid more only when they do more, and all physicians fear malpractice suits. Second, patients need much better information on the risks, benefits, and uncertainties of specific interventions and on the actual quality of their providers. As long as patients are left to rely solely on the biased adver-

tising of drug and device manufacturers — and on the assertions of providers who promote unproven treatments and exaggerate their own performance — more care will look like better care.

The third area is less familiar but is highlighted in the article by Ashton et al. The contributions of the local supply of hospital beds and the composition of the medical workforce to both spending and quality need to be addressed.<sup>6</sup> Local supply has largely been ignored as a tool for improving the quality and efficiency of care, but it could offer important advantages in this regard. Constraints on capacity set upper limits on the utilization of health care services. They also ensure, at least for some services, such as major surgery, that expertise is maintained through an adequate volume of procedures.<sup>13</sup> Constraints on capacity are more respectful of physicians' autonomy and judgment than intrusive attempts to micromanage clinical decisions.<sup>14</sup>

This brings me back to the VA and its relevance to the rest of the U.S. health care system. The VA is notable not only for its commitment to a primary care-based model of managed care that the rest of the country seems to be abandoning, but also for its efforts to improve quality through performance measurement and a focus on getting the incentives right.<sup>3</sup> Some of the VA's measured improvement<sup>3</sup> may simply reflect better documentation and the diversion of clinicians' efforts to what some believe are trivial tasks. The VA's performance is still uneven,<sup>3</sup> and barriers to access remain.<sup>15</sup> But unfettered growth and unmanaged care pose serious risks to health. The VA's approach deserves a second look.

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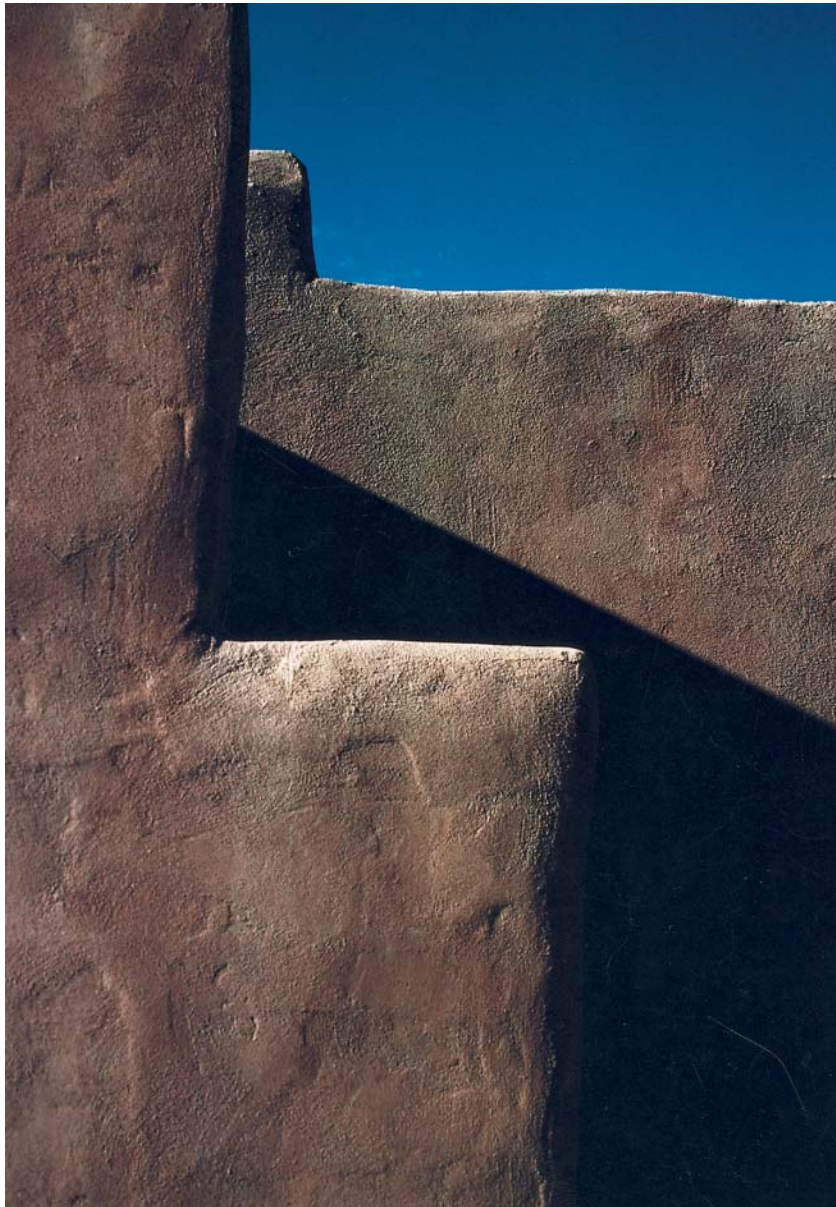
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