"The Cost Conundrum "
Emergency Medicine Journal Club Discussion
Eastern Virginia Medical School

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Article Overview

The Cost Conundrum, Atul Gawande. *The New Yorker.* June 1, 2009

McAllen, TX and the "Culture of Money"

- Gawande undertakes a case study of the healthcare industry in McAllen, Texas, the most expensive healthcare market in America with Medicare expenditures of $15,000 per enrollee in 2006.
- In "The Cost Conundrum" McAllen, Texas, a border town with the lowest household income in the country, is compared with lower cost healthcare markets composed of both similar and different demographics.
- Gawande toured healthcare facilities, met with administrators and physicians, and consulted expert analysts on healthcare costs and exposed the reason for skyrocketing medical expenditures in McAllen - the gross overuse of medical resources.
- The Dartmouth Institute for Health Policy and Clinical Practice has published extensive analysis on Medicare spending and health quality and found that the more money Medicare spent per person in a given state the lower that state's quality ranking tended to be.
- In the words of one McAllen hospital administrator, the city's healthcare system is dominated by the "culture of money"
- Gawande refers to the "anchor-tenant" theory of economic development to explain how McAllen's healthcare market came to be as it is today. He hypothesizes that the "anchor" institutions in McAllen enabled the commercialization of medicine and high profit margins set the norm for what others did.

The Mayo Clinic and Accountable Care

- After analyzing the source of McAllen's healthcare cost crisis, Gawande turned to evaluate healthcare markets that are keeping cost under control while providing high quality care.
- The Mayo Clinic is one of the highest-quality, lowest-cost healthcare systems in the US who's core value is that "the needs of the patient come first."
- The Mayo Clinic model proved to be exportable to more expensive health care states, and has become a prime example of an an **accountable-care organization:** The hospital system and leading physicians adopt measures to blunt harmful financial incentives, and take collective responsibility for improving the sum total of patient care.
- Gawande concludes that we are witnessing "a battle for the soul of American medicine." He states that funding for research that compares the effectiveness of different systems of care is necessary to reduce our uncertainty about which systems work best. The ultimate questions

according to Gawande is, Whom do we want in charge of managing the full complexity of medical care?

Discussion Points

Article

1) **Where do you think the Hampton Roads Health-care community lies on the spectrum of accountable care?**

2) **Do you think Gawande sufficiently accounted for social determinants of health such as the predisposition for poorer health in populations with less income and education?**

The Affordable Care Act and Gawande's Cost Conundrum

Gawande's Analysis of the Senate health-care bill:
"Testing, Testing" *The New Yorker.* December 14, 2009.

- In this article Gawande speaks to the question of whether the legislation will adequately address the problem of soaring medical costs. Both democrats and republicans have criticized the bill for lack of a master plan to control expenditures.
- Gawande uses the example of early 20th century USDA programs that were implemented to solve the agricultural crisis in which farm inefficiency was causing low crop yields, high prices, limited choice, and uneven quality.
- He likens the USDA's successful agriculture reform, which encompassed several trial programs, to the pilot programs offered in the senate healthcare reform bill.
- Gawande argues, "The history of American agriculture suggests that you can have transformation without a master plan, without knowing all the answers up front. Government has a crucial role to play here—not running the system but guiding it, …. To figure out how to transform medical communities, with all their diversity and complexity, is going to involve trial and error. And this will require pilot programs—a lot of them."
- Gawande sites a pilot program in the bill that would encourage clinicians to band together into **"Accountable Care Organizations"** that take responsibility for all their patients' needs, including prevention.
- The legislation also continues a stimulus-package program that fund**s comparative-effectiveness research**—testing existing treatments for a condition against one another—because fewer treatment failures should mean lower costs
- In the end, the Senate bill contains a test of almost every approach that leading health-care experts have suggested. (The only one missing is malpractice reform.) Among the most important, and least noticed, provisions in the reform legislation is one in the House bill to expand our ability to collect national health statistics.

3) **How Successful do you think that Healthcare reform, as it is currently taking shape, will be in assuring high quality accountable care and curbing healthcare costs?**

Implications of health care reform on Emergency Medicine

Millard, William B, PhD. "How Universal Coverage Could Change Emergency Medicine, and Vice Versa" *Annasl of Emergencyy Medicine.* Volume 54, Issue 2. (August 2009).

- "Universal health care for emergency medicine is a double, maybe triple-edged sword," comments Dr. Schneider: beneficial in reducing the burden of EMTALA's unfunded mandate and increasing the proportion of ED visits resulting in payment, but capable of backfiring if primary care providers end up refusing a new public insurance card, as some physicians now refuse Medicare, Medicaid, and the state-level plans

- James C. Mitchiner, MD, MPH, of Emergency Physicians Medical Group and Saint Joseph Mercy Hospital in Ann Arbor, Mich., speaks to the implications of healthcare reform on potentially increasing payment for emergency care.
    - "Emergency physicians: we basically live in a single-payer world, we see everybody regardless of what insurance they have, or even if they have no insurance … and if you think about it, emergency doctors get a single check every month regardless of whether they're employed by the hospital or, like me, they work for a group. I could only imagine how much bigger that check would be if we got paid on 100% of the patients we saw, even if it was at Medicare rates."

- Dr. Kellerman, associate dean of emergency medicine at Emory University addressing the problem of rationing care based on ability to pay: " We ration more ruthlessly and more aggressively on a day-to-day basis than any other industrialized nation, but we ration based on the ability to pay, and we sell on the basis of what the market's willing to bear, without necessarily regard for whether it's what the patient really needs."

4) **In light of Gawande's discussion of the "cult of money" and the proposed healthcare legislation, how do you think that healthcare reform will impact emergency medicine, ED crowding, and the soaring cost of healthcare in our country?**

Table 1 Medicare Spending per Enrollee and Spending Growth among Hospital Referral Regions, 1992-2006

Hospital Referral Region	State	Inflation-adjusted	Inflation-adjusted	Growth in	Annual Growth Rate 1992-

		total medicare spending per enrollee, 1992	total medicare spending per enrollee, 2006	Spending ($/person), 1992-2006	2006
McAllen	TX	4,891	14,946	10,055	8.31%
Norfolk	VA	4,720	7,133	2,413	2.99%
	VA	4,303	6,856	2,553	3.38%
USA	Average	5,110	8,304	3,193	3.53%

(ES Fischer, 2009)[1]

HOUSE-SENATE COMPARISON OF KEY PROVISIONS

The House- and Senate-passed health reform bills are based on the plan set out by President Obama in his campaign and shaped during the legislative process. As a result, they have substantial similarities that will greatly facilitate the final step of developing an agreement on a bill for the President's signature. Both bills:

- Provide a comprehensive set of "early deliverables," starting in 2010, which include

(1) initial insurance reforms and consumer protections
(2) a new insurance pool to make coverage available to individuals with pre-existing conditions or chronic illnesses who can't get coverage today
(3) Disclosure, review and justification of insurance rate increases.
Both bills also contain additional early investments in community health centers and the workforce, which are essential both to ensure access when the coverage reforms are implemented go into place and to begin to improve both personal and community health and wellness immediately. Additional Medicare improvements, including beginning to close the donut hole, also begin in 2010.

- Improve insurance coverage by implementing major coverage reforms (2013 in House bill, 2014 in Senate) and providing financial assistance to lower- and middle-income families and small businesses. Those provisions include:

Insurance reforms, minimum benefit standards, and creation of a new health insurance marketplace called an "exchange" where health plans compete based on price and quality for individual and small employer business.

Increases in Medicaid eligibility levels for those with the lowest income, and new funding for critical safety net services through community health centers.

Sliding scale financial credits to ensure affordable premiums and cost-sharing assistance for households with income above new Medicaid income levels but below 400 percent of the federal poverty level.

Individual responsibility to purchase insurance within this new framework.

Employer responsibility to offer coverage or provide financial contributions to help pay for coverage.

- Improve Medicare coverage for prescription drugs and preventive services, and implement major Medicare delivery system and payment reforms to make Medicare more efficient and restrain future spending growth. Both bills institute numerous long-term reforms that experts

[1] Elliot Fischer, MD, MPH. Julie Bynum, MD, MPH, Jonathan Skinner, PhD. "The Policy Implications of Variations in Medicare Spending Growth.: The Dartmouth Institute for Health Policy and Clinical Practice.

have called for to enhance quality and value for Medicare beneficiaries and the entire health care system.

- Provide revenues that, coupled with the program savings above, meet the commitment of the President, the Speaker and the leaders of the House and Senate that the bill be fully paid for. In fact, both bills actually reduce the deficit by more than $100 billion over the first 10 years, and are projected to yield savings in the second 10 years.

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