

# Scapegoats in White Coats

Doctors are not to blame for the high cost of medical services

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**L**isten to almost any diatribe against the health-care system and you will hear the same refrain: We are getting too little care and paying too much for it. And, more and more, we are hearing that the villains behind this are not oppressive government regulators or meddling insurance-company bureaucrats — but doctors.

Doctors, after all, make all the important decisions, editorializes the *New York Times*: "Many do a lot more than is medically useful — and often reap financial benefits from over-treating their patients. . . . Some are unabashed profiteers." If we really want to fix things, says Steven Pearlstein of the *Washington Post*, all that "really matters is changing the ways doctors practice medicine"; everything else "is just tinkering at the margin."

President Obama himself made the case to the American Medical Association (AMA). He began by running through the litany of cost-control proposals that he advanced during last year's campaign: preventive medicine, electronic medical records, evidence-based medicine, coordinated care, etc. But then the president admitted (apparently for the first time) what his advisers have said many times: These reforms will make only "a dent" in the problem. The real reason for out-of-control medical spending, he told the doctors, was unnecessary care. Drawing on research by investigators at Dartmouth, he said: "McAllen, Texas, is spending twice as much as El Paso County — not because people in McAllen are sicker and not because they are getting better care. They are simply using more treatments — treatments they don't really need; treatments that, in some cases, can actually do people harm by raising the risk of infection or medical error. And the problem is, this pattern is repeating itself across America."

So what's the answer? Government, the president said, must change the way physicians are paid. It must discover the best practices, reward doctors who follow them, and penalize those who don't. Instead of letting doctors do whatever they think is in the best interest of their patients, we must force them to follow national standards set by federal agencies. Government, in other words, must begin telling doctors how to practice medicine.

The doctors at the AMA meeting gave the president a standing ovation. Were they just being polite? Or did they not understand what they were hearing? If not, they soon will.

The president's point man on these issues, budget director Peter Orszag, is more explicit. Dartmouth researchers have been studying Medicare spending patterns for years, says Orszag, and — just as with McAllen and El Paso — they've discovered wide variations in Medicare costs that seem to have no relation at all to the health outcomes of the patients. Assuming that there is no reason to spend more rather than less, the Dartmouth group concludes that if doctors across the country practiced medicine the way doctors in the lowest-spending areas do, we could reduce total Medicare spending by one-third with no harm to patients. Orszag calculates that the potential savings could be a whopping \$750 billion a year. That's enough to cover about half the

cost of Obama's health-reform plan.

Of course, to get even close to realizing that level of savings, doctors almost everywhere would have to change — in some cases, radically — what they are now doing. And that, of course, would require a lot of friendly persuasion. But with the power of the purse (government already spends almost half the U.S. health-care dollars), Orszag reasons that this is doable.

There's only one problem: The entire edifice on which this thinking is erected may be completely wrong. Is it really true that doctors around the country spend vastly different resources to achieve the same outcomes? The implicit assumption Orszag is making is that the doctors who treat Medicare patients must be treating their non-Medicare patients the same way. But this assumption, it turns out, is not true. Differences in Medicare spending are, in many cases, offset by spending on other patients. For example: Although Texas is fifth from the top in Medicare spending per capita, it is seventh from the bottom in per capita spending for the state's population as a whole. And California is eleventh from the top in Medicare spending, but eighth from the bottom in spending overall.

What's going on here, probably, is "cost shifting." When Medicare underpays, doctors, hospitals, and other providers try to recoup their losses by overcharging other patients. To the degree that cost shifting is going on, we would expect an inverse relationship: When Medicare pays less, private patients tend to pay more, and vice versa.

Take McAllen, Texas, for example. This is an area with large numbers of low-income, uninsured patients — to say nothing of all the immigrant patients who need only wade across the Rio Grande to get U.S.-quality health care. It may be that McAllen providers are running up Medicare charges in order to subsidize the free care they are giving so many others.

And that brings us back to the original question: How much could we save by changing the way doctors practice medicine? In a study soon to be released by the National Center for Policy Analysis, Texas A&M economists Andrew J. Rettenmaier and Thomas R. Saving say that when the focus is on health spending for the whole population, Peter Orszag's dreams are dashed: There is in fact very little to be gained by trying to force doctors across the country to emulate their lowest-spending peers.



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Does all this mean that the Dartmouth researchers are way off the mark? Not entirely. One of their important findings is that there really are centers of excellence that practice low-cost, high-quality medicine. Take the Mayo Clinic: If everyone in America went to Mayo for his health care, we could cut health-care spending by one-fourth and the quality of care would go up. If everyone in America went to Intermountain Healthcare in Salt Lake City, we could cut health spending by one-third and quality would increase. The problem is, not everyone can go to these facilities. Even worse: We don't know how to replicate their behavior. We don't know how to make every clinic a Mayo Clinic, or every hospital like Intermountain Healthcare.

In some ways, the health-care system is similar to the education system. In both, we find pockets of excellence. But since there is no real market, there are no sustained financial rewards for excellence. To the contrary, excellence is usually penalized. Most hospitals, for example, make money on their mistakes. If patients have to be readmitted because they were not cared for properly, the hospital takes the opportunity to bill again. By contrast, a facility like Mayo, with a low readmission rate, loses money because it is efficient. The profit-maximizing thing to do in health care is to provide high-cost, low-quality care rather than the other way around.

Which brings us back to the doctor. Have you ever noticed that the entry space of the offices of lawyers, accountants, engineers, architects, and other professionals is called a "reception area" — and that at doctors' offices, by contrast, it is called a "waiting room"? There's a reason for that. The primary way Americans pay for health care is the same way the British, Canadians, and Europeans do: We pay not with money, but with time.

Were doctors free to deal with their clients as other professionals do, they would recognize that the patient's time is valuable. Competition for patients would induce doctors to find ways of lowering the time cost of care as well as the money cost. But, unlike all other professionals, doctors have no power to repackage and reprice their services. Medicare, for example, has about 7,500 tasks it will pay for, with a predetermined price for each. When the doctor is doing one of the 7,500 reimbursable things, he or she can bill Medicare. If a task is not on the list, no matter how patient-pleasing it is, there will be no payment. Most private insurers pay the same way.

As a result, doctors relate to patients today pretty much the same way they did 100 years ago. Sometime early in the 20th century, all the other professions discovered the telephone — but even today, most doctors do not consult by phone, even for routine maladies. The reason: Telephoning, for all practical purposes, is not on Medicare's list of reimbursable tasks. Similarly, everybody e-mails everybody these days — except doctors and patients. This is another activity that is not on Medicare's list. Most doctors don't have their client records on a computer. This is all the result of an antiquated, inflexible, bureaucratic, and dysfunctional system of third-party payment of medical bills.

But is any of this the *doctor's* fault? Only in a very roundabout way: The AMA agreed to this method of payment. The typical practicing physician, however, did not agree. Most would undoubtedly like to have the same flexibility that other professionals have. And a growing number are gaining that freedom.

Once called "concierge doctors," and today called "direct-practice doctors," these are physicians who refuse all third-party payment. They typically consult by phone and e-mail. They usually have electronic records and prescribe electronically. They help their patients navigate the complexities of the health-care system — negotiating lower prices, say, for MRI scans and specialists' services. Some even make house calls.

The direct-practice physicians are illustrating that doctors are not the problem — they are the solution. They do not need more orders from third-party-payer bureaucracies. What they need is to be liberated.

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