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**FROM SACRAMENTO TO LOS ANGELES,  
MORE HEALTH CARE IS NOT NECESSARILY BETTER HEALTH CARE**

***\* New Study Shows Medicare Pays Some California Hospitals Four Times More Than Others, Without Improving Results or Patient Satisfaction***

***\* Correcting "Medicare Overcare" Could Save \$1.7 Billion over Five Years in Los Angeles Area Alone***

Oakland, CA – November 16, 2005 – Medicare pays some California hospitals four times more than others to care for patients with similar chronic illnesses, with no gain in quality or patient satisfaction, according to a study by the Center for the Evaluative Clinical Sciences at Dartmouth Medical School.

The ground-breaking study, released today by the California HealthCare Foundation, looks at the performance of individual California hospitals in managing seriously ill patients over a five-year period. The findings, along with a comparison of data from hospitals in five regions in California—Sacramento, San Francisco, Los Angeles, Orange County, and San Diego—also were published today in a Web Exclusive edition of the journal *Health Affairs*. Concurrently with the release of the *Health Affairs* article, the Dartmouth Atlas of Health Care project is publishing performance measures for California hospitals on its Web site.

The study reveals that average spending per patient varied by a factor of four among hospitals in the state. The additional care provided in some regions and hospitals did not improve medical outcomes or patient satisfaction; in fact, as the volume of care increased, the quality of care and patient satisfaction declined. The study also found that improved hospital efficiency could have saved Medicare \$1.7 billion over five years in Los Angeles alone.

“Medicare faces a serious ‘overuse’ problem, which is significant given its fiscal problems,” says John E. Wennberg, M.D., M.P.H., the study’s principal investigator and director of the Center for the Evaluative Clinical Sciences at Dartmouth Medical School in Hanover, NH. “This study documents with new specificity how care for seriously ill patients varies widely from hospital to hospital and region to region, and that Medicare is not providing patients with better care by paying more. There are significant opportunities to improve efficiency.”

“This new study should stimulate a robust debate over efficiency and value in health care. We need to simultaneously provide better treatment for patients with chronic illness and pay close attention to spending so our health dollars are spent as wisely as possible,” said Mark D. Smith, M.D., M.B.A, president and CEO of the California HealthCare Foundation. “The growing use of quality indicators to rate and reward providers must be accompanied by measures of efficiency to balance the picture of health care performance.”

The California study was underwritten by the California HealthCare Foundation and the Robert Wood Johnson Foundation, a longtime funder of the Dartmouth Atlas project. The report and data released today are precursors to the release early next year of a study and data on all U.S. hospitals.

The data used in this study, and being made available to the public today for the first time, enables direct comparisons of the efficiency of individual hospitals in treating patients with chronic illness based on the actual Medicare claims from a hospital and its associated physicians. The results make it possible to compare and rate regions, as well as individual hospitals on the efficiency with which they use health care resources.

“This new work confirms that more care is not necessarily better care,” says co-author Elliott S. Fisher, M.D., M.P.H., senior associate at the VA Outcomes Group and professor of medicine and of community and family medicine at Dartmouth Medical School. “The higher use found in California, as elsewhere, reflects a delivery system in which services are driven not by patient need, but by the relative availability of resources. In regions that have more hospitals, more ICU beds, more physicians and more specialists, patients receive significantly more services at greater cost, but with no improvement in outcomes.”

The comparisons reveal where savings could be achieved without reducing quality by improving efficiency. For example, Medicare could have saved \$1.7 billion in the Los Angeles market alone if care patterns in Los Angeles, the most expensive region, mirrored those of Sacramento, the study notes.

“This data is relevant beyond California and beyond Medicare, because it tells us that we have to fundamentally re-design the ways we care for the millions of Americans with chronic illness. We need information like this to ensure that our health care dollars are spent on high-quality health care that results in better outcomes for patients,” said Risa Lavizzo-Mourey, M.D., M.B.A., president and CEO of the Robert Wood Johnson Foundation.

### **How Hospital Care in the Golden State Varies by Region**

The Dartmouth Atlas project examined Medicare data from the 226 California hospitals with more than 400 deaths from 1999 to 2003. Patients included in the study had at least one of 12 chronic illnesses. Two-thirds of patients were diagnosed with cancer, congestive heart failure and/or chronic lung disease. This study focused only on patients who died so that the investigators could be sure that patients were similarly ill across hospitals. Previous studies have shown that the care of patients at the end of life is an accurate indicator of how efficiently hospitals care for seriously ill patients in other periods of their lives. The study also demonstrates that care patterns in the last six months of life are very similar to the levels of care given during the entire last two years of life.

Among all California hospitals, Medicare spent amounts ranging from less than \$20,000 to more than \$90,000 per person on inpatient hospital care during the last two years of life. Two-thirds of this variation was associated with the number of days patients spent in the hospital. Only 39 percent of the variation was associated with the price of each day's stay. Thus, the volume of care received—how many times a patient was admitted to the hospital and how many days they spent there—was a far more important driver of total costs to the Medicare program than the daily rate charged by the hospital. Total Medicare spending—hospital payments plus payments to physicians—ranged from \$24,722 to \$106,254 per person.

Los Angeles was the most costly region. The average Medicare payment for inpatient hospital care was \$43,506 per Los Angeles decedent during the last two years of life—20 percent higher than the average in San Francisco, 36 percent higher than Orange County, 44 percent higher than San Diego, and 67 percent higher than Sacramento. Total Medicare spending, including physician services, was similarly skewed.

When compared to Sacramento, the least expensive region, patients in Los Angeles had:

- 2.3 times more physician visits;
- 3.3 times more visits to medical specialists;
- 2.31 times more days in intensive care; and
- 1.62 times more days in the hospital.

There was similar variation within Los Angeles itself, within hospital systems operated by a single owner and among academic medical centers.

Among hospitals in Los Angeles, the range of total Medicare spending per decedent for hospital care ranged from a high of \$106,300 to a low of \$38,600 during the last two years of life.

### **Hospital Systems and Academic Medical Centers Vary Too**

Among the three hospital systems in California with more than 15 hospitals that had at least 400 deaths during the study period, Medicare inpatient spending over the last six months of life varied by a factor of 2.2 among hospitals belonging to the Sutter Health System; by a factor of 2.7 among Catholic Healthcare West hospitals; and by a factor of 3.5 among Tenet hospitals in California.

Among academic medical centers, the most striking differences were those between UCSF and UCLA. UCLA, like many other hospitals in the Los Angeles region, managed chronic illness aggressively. Compared to UCSF, UCLA patients spent 45 percent more days in acute care hospitals, used 3.5 times more days in intensive care and were 1.5 times more likely to have been admitted to an ICU during the hospitalization in which they died. They experienced 71 percent more physician visits and 37 percent more frequent referrals to ten or more different physicians.

### **Possible Solutions**

Addressing overuse will require engaging providers and payors in an effort to better rationalize the amount of resources in hospital markets, according to the report's authors. Payors should not be "penny wise and pound foolish" when selecting providers for their networks, by considering only the unit cost of services. Payors should instead consider the total cost of caring for patients as a measure of efficiency and the prudent use of resources. Hospital management must make key decisions that determine capacity in their communities as well as examine the efficiency of physicians with admitting privileges in their hospitals.

*Health Affairs*, published by Project HOPE, is a bimonthly multidisciplinary journal devoted to publishing the leading edge in health policy thought and research. Copies of the November 16, 2005, Web Exclusive article, "Evaluating the Efficiency of California Providers in Caring for Patients with Chronic Illness," will be available online until November 30, 2005, at [www.healthaffairs.org](http://www.healthaffairs.org). Data by California region and by specific California hospitals is available on the Dartmouth Atlas site at [www.dartmouthatlas.org](http://www.dartmouthatlas.org)

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### **About the California HealthCare Foundation**

The California HealthCare Foundation (CHCF), based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Visit [www.chcf.org](http://www.chcf.org) for more information.

### **About Dartmouth Atlas Project**

The Dartmouth Atlas Project began in 1993 as a study of health care markets in the United States, measuring variations in health care resources and their utilization by both geographic areas. More recently, the research agenda has expanded to reporting on the resources and utilization among patients at specific hospitals. DAP research uses very large claims databases from the Medicare program and other sources to define where Americans seek care, what kind of care they receive, and to determine whether increasing investments in health care resources and their use result in better health outcomes for Americans.

### **About The Robert Wood Johnson Foundation**

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 30 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit [www.rwjf.org](http://www.rwjf.org).