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Taming Wide Variations in Spending Key to Health Reform—*New England Journal of Medicine* Commentary from Dartmouth Atlas Project

***Dallas Medicare spending is growing twice as fast as San Diego.
The system rewards physicians for providing care even when it is not needed.***

Lebanon, N.H. (February 26, 2009) – The cost of providing health care to seniors is rising more than twice as fast in Dallas as in San Diego, and Medicare now spends nearly three times more to care for its enrollees in Miami than it does in Honolulu. This illustrates how huge inefficiencies in the U.S. health care system are hamstringing the nation’s ability to expand access to care, according to a new analysis of Medicare spending by researchers of the Dartmouth Atlas Project published today in the *New England Journal of Medicine*.

Many experts have blamed the growth in spending on advances in medical technology. But the differences in growth rates across regions show that advancing technology is only part of the explanation. Patients in San Diego have access to the same technology as those in Houston, and those in low-cost regions are not deprived of needed care. On the contrary, the researchers note that care is often better in low-cost areas.

The authors argue that the differences in growth are largely due to discretionary decisions by physicians that are influenced by the local availability of hospital beds, imaging centers and other resources—and a payment system that rewards growth and higher utilization.

“To paraphrase a line from the gun control debate: technology doesn’t drive the growth in health care spending; people do,” said lead-author Dr. Elliott Fisher, principal investigator for the Dartmouth Atlas Project and director of the Center for Health Policy Research at the Dartmouth Institute for Health Policy and Clinical Practice. “The good news is that in many regions, spending is growing relatively slowly. Reformers can learn from these regions and put in place policies that help them sustain what they are doing now, and encourage high-cost, high-growth regions to change their ways.”

The researchers calculated the growth rate of Medicare spending per enrollee from 1992-2006. In the article, they analyzed spending differences in 306 local health care markets. The results are also available for states.

Nationally, Medicare spent an average of \$8,304 per enrollee in 2006, and national spending grew at a rate of 3.5 percent annually from 1992 to 2006. Among states, New York was tops in spending per enrollee, at \$9,564. Hawaii was lowest, at \$5,311. The growth rates and spending

per enrollee do not always track, as some high-growth states started from a low base, and vice versa. Nebraska had the highest growth rate, at 5.3 percent, although it was 39th on spending per enrollee, at \$6,922. In contrast, the District of Columbia had the lowest growth rate, at 1.6 percent, although it was 29th in spending, at \$7,551 per enrollee.

Where Medicare spending per enrollee grew at an annual rate of 5 percent in Miami, the rate was less than half, at 2.4 percent, in San Francisco. Medicare spent \$16,351 per enrollee in Miami in 2006, almost twice the spending of \$8,331 in San Francisco.

The contrasting history of spending in San Francisco and East Long Island shows how even a slight difference in growth rates can make a large difference over time. Both regions had nearly identical spending per enrollee in 1992. But where San Francisco grew at 2.4 percent for the next 14 years, spending in East Long Island exploded at 4 percent. So, by 2006 spending in East Long Island was \$2,300 more per enrollee than in San Francisco—about \$1 billion in additional annual Medicare spending in a single region.

The researchers project that, at current spending rates, Medicare will be \$660 billion in the red by 2023. But by reducing the annual growth in per capita spending from 3.5 percent, the national average, to 2.4 percent, the rate in San Francisco, Medicare could save \$1.42 trillion and turn the deficit into a healthy surplus.

“The good news is that small differences, because of compounding, can make an enormous difference for the long-term solvency of Medicare and our ability to expand coverage for the uninsured,” said co-author Jonathan Skinner, Ph. D., the John Sloan Dickey Third Century Chair of Economics at Dartmouth College.

The authors call on physicians to lead an effort to reform how the U.S. delivers and pays for health care to bring spending under control. They write: “Payment systems could then shift from purely volume-based payments to systems ... that foster accountability for the overall costs and quality of care, allowing physicians to align their work more closely with the values that brought them to health care. “

“This work demonstrates why health reformers should work to realign private and public payment schemes to benefit quality performance over the volume of services,” said Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation. “Clinicians who successfully provide high quality care and slow spending growth should be rewarded, not penalized.”

“This is an opportunity for physicians to lead,” said Dr. Julie Bynum, co-author and assistant professor of Medicine at Dartmouth Medical School. “But even though doctors still make most of the critical decisions about how and where their patients get care, they will need help from payers and policymakers. Physicians operate under the rules of a system that is rigged to reward high-cost care.”

The Dartmouth Atlas Project is run by the Dartmouth Institute for Health Policy and Clinical Practice. The principal funding for the project comes from the Robert Wood Johnson Foundation. Funding for this research was also provided by the National Institute of Aging.

A link to the commentary, the data tables, an interactive map displaying the data, and two new policy briefs explaining variations in Medicare spending are available at www.rwjf.org/goto/dartmouthatlas and www.dartmouthatlas.org.

About the Dartmouth Atlas Project

For more than 20 years, the Dartmouth Atlas Project has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide comprehensive information and analysis about national, regional, and local markets, as well as individual hospitals and their affiliated physicians. These reports, used by policymakers, the media, health care analysts and others, have radically changed our understanding of the efficiency and effectiveness of our health care system.

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