

McAllen versus El Paso, Part II

In June 2009, writer and surgeon Atul Gawande, M.D., shocked the nation when he exposed the enormous difference in Medicare spending between McAllen and El Paso, Texas, two otherwise similar towns. Using data from the *Dartmouth Atlas of Health Care*, Gawande reported that Medicare spent about \$15,000 per beneficiary in McAllen in 2006—nearly twice as much per beneficiary as in El Paso. But though Gawande’s *New Yorker* article may have answered a number of tough questions about the reasons for that discrepancy, for Dartmouth health economist Jonathan Skinner, Ph.D., it left one very important question unanswered: Did spending patterns seen in the Medicare population exist for people under 65?

To find out, Skinner teamed up with two University of Texas professors to analyze data from Blue Cross and Blue Shield (BCBS) of Texas, the largest private insurer of under-65 individuals in the state.

Patterns: “Surprisingly, and in contrast to the Medicare data,” wrote the researchers in *Health Affairs*, “total spending per BCBS member was actually slightly lower in McAllen than in El Paso.” That conclusion raised another question: how to explain the difference in spending patterns for Medicare and non-Medicare patients.

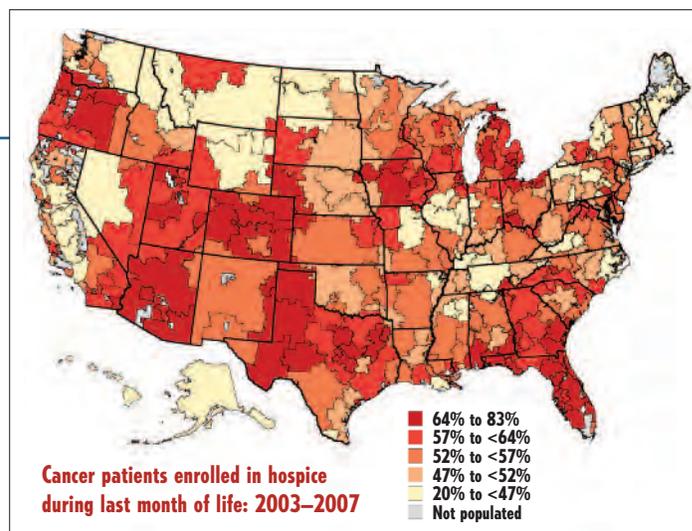
One possibility, Skinner says, is that “physicians responded differently depending on the insurance company that was reimbursing them.” Gawande argued that one reason for high Medicare spending in McAllen was that providers there had created a “culture of money,” something Skinner says is consistent with his findings. McAllen doctors increase their “use of profitable Medicare services when there is diagnostic and procedural discretion and clinical latitude,” Skinner and his coauthors noted, meaning that physicians there tend to take an aggressive approach to treatment whenever the best course of action is a judgment call. Medicare patients are by definition older than BCBS patients and so typically would need more tests and procedures, but whether such things are always necessary remains up for debate.

Another reason for high Medicare spending in McAllen may be Medicare’s lack of utilization review, a process that private insurance companies—such as BCBS—use to determine whether procedures are truly necessary. Without utilization review, unnecessary tests and procedures could be ordered without repercussions, increasing physician and hospital revenues and adding unnecessarily to Medicare spending. But, given the much lower health-care costs for Medicare beneficiaries in El Paso, utilization review, or the lack thereof, cannot be the only cause of the high cost of care in McAllen.

Puzzle: As with Gawande’s article, Skinner’s new study answers some important questions but also brings to light a number of new ones that will surely fuel the continuing effort to piece together the puzzle of variations in health-care delivery.

Skinner teamed up with two University of Texas professors.

GEOFFREY HOLMAN



This is one of the maps in a new *Dartmouth Atlas* report focused on cancer care.

Cancer care: “Tragic underservice”

A new report by the Dartmouth Atlas Project, the first to focus specifically on cancer care, shows that whether patients with advanced cancer die in a hospital or while receiving hospice care varies greatly across regions and academic medical centers.

The Dartmouth researchers studied 235,821 Medicare patients age 65 or older with aggressive or metastatic cancer who died between 2003 and 2007. They found that in many parts of the country, over a third of patients spent their last days in hospitals; the range was from a high of 46.7% in Manhattan to a low of 19.6% in Fort Lauderdale, Fla. Many of the hospitalized patients received aggressive care, such as feeding tubes. And although chemotherapy was used in the last two weeks of life for 6% of all patients nationwide, in some areas the rate exceeded 10%; in Olympia, Wash., for example, it was 12.6%.

Patients’ care varied in other ways as well. For example, over 40% of patients were admitted to intensive care during the last month of life in Huntsville, Ala., but only 6% in Mason City, Iowa.

Intensive: There were variations in care even for patients hospitalized in academic medical centers. For example, 46.1% of patients were admitted to intensive care in the last month of life at St. John Hospital and Medical Center in Detroit, compared to only 8.9% of patients at Memorial Sloan-Kettering in Manhattan. In at least 50 academic medical centers, less than half of these patients with advanced cancer were receiving hospice services.

Patients, the researchers argue in their report, need to be made more aware of their choices and of what those choices mean. “Many patients find little opportunity to explore these preferences as the clinical team ‘fights’ the battle against an illness that has no cure,” the authors wrote. “The slow pace of adoption of early palliative care for patients with serious cancer is a tragic underservice of health care, leading to much unnecessary suffering.”

“When it’s likely to be a very shortened life span,” says lead author David Goodman, M.D., “patients want to understand how they can live long, but also how they can live well.” MATTHEW C. WIENCKE