



12 Ways Health Reform May Improve Care and Save Costs

Cheryl Clark, for HealthLeaders Media, August 11, 2009

Uncle Sam is poised to spend \$1.1 billion in stimulus funds to compare the effectiveness of 100 treatment categories in coming years, so providers, taxpayers, and insurance premium payers will stop wasting money on worthless care.

But many experts say there's already enough evidence to start changing clinical practice to cut waste, improve outcomes, and save as much as 30% of what is being spent today.

There are 12 possible ways that health reform could look to improve care while saving costs:

1. If health reform creates a public plan, the federal government will have to make decisions on whether to spend money on procedures like vertebralplasty. Researchers point out this is not to ration care, but to approve spending to target only that which has been shown to make people better, and live longer, more enjoyable lives.

Last week in the [New England Journal of Medicine](#), two studies [compared vertebralplasty](#), a surgical procedure on the vertebrae done in 8.9 per 1,000 persons in the U.S, with a simulated or "sham" procedure.

Both groups of patients reported the same improvements in pain and disability, even six months later. [An accompanying editorial](#) carried a colorful chart of the country showing such wide variations in use of the procedure, 66 regions in the nation used the procedure 30% higher than the national average while 105 regions used it 25% less frequently.

As described in another [New England Journal of Medicine article published Monday](#), Dan Callahan decried an April 29 Senate Finance Committee report that demands that those conducting comparative effectiveness research with that \$1.1 billion "should be prohibited from issuing medical practice recommendations or from making reimbursement or coverage decisions or recommendations."

Callahan called it "the first shot across the bow of serious cost reform."

Research is essential to use science to inform the process through which patients and doctors make honest and realistic decisions based on the best interests of the patient. When that happens, there will be a lot of avoided costs, not to mention avoided risk, from unnecessary tests, procedures, and medications.

Researchers with the Dartmouth Atlas crunched Medicare utilization data throughout each region and county in the country and determined that up to 30% of Medicare dollars are wasted each year, in part because of wide variations in care practices.

Douglas Wood, MD, of the Mayo Clinic in Rochester, MN, and Joe Scherger, MD, chairman of the Right Care Initiative of the Rand Corp., and a clinician at Eisenhower Medical Center in Rancho Mirage, CA, helped prepare a list of procedures, drugs, and screenings that offer little or no benefit, yet are commonly used in healthcare, often at tremendous and unnecessary expense.

2. Coronary stents may be overused by 30%, and far too many bypass graft procedures are done on patients who could be better, more safely managed with medications. Since concern about stent thrombosis incidents that occurred after drug eluting stents were implanted, the number of stent placements has started dropping, which Wood says "is a pretty good clue we were overusing them."

At the Mayo clinic, Wood says, the same cardiologist does not do the exam, the angiogram, and the angioplasty. "Here there are at least two opinions before you get an angioplasty," he says.

3. Coronary calcification screening in asymptomatic people over age 70 may be a waste of money. "Most people of that age have coronary calcification, but it won't predict whether they are going to have a heart attack," Wood says. With these expensive tests comes an increased risk of cancer from radiation. A recent study found between 42 and 62 extra cases of cancer per 100,000 people would occur over the course of their lives if they underwent such tests every five years, after age 45 for men and 55 for women.

4. Ultrasounds in pregnant women at 20 weeks are not that useful. "It's just become an expectation of mothers who want to have a picture of their baby," Wood says.

5. Use of generics rather than brand name drugs and more intelligent use of channel blockers and ace inhibitors in patients with heart failure, heart disease, high blood pressure, and diabetes. Wood calls it a move toward "rational prescribing.

"I see a number of patients who are taking nine or 10 medications, where we could probably get by with six," Wood says. Use of generic diuretics for high blood pressure are effective, inexpensive, and underutilized in part because brand name drug advertising steers patients and physicians toward more expensive products that aren't always more effective.

6. Use of generic statins to control cholesterol instead of higher priced brands such as Lipitor. Wood says "the results are generally the same. Once in a while, I see a patient who does not respond to generic statins, but it's pretty rare."

7. Expensive chemotherapy drugs used too long after they have stopped working. "Unfortunately, we're not using any restraint in cancer therapy. And the number of patients with terminal, metastatic cancer who are given an opportunity to have hospice care is still way too low," Scherger says. "We subject them to incredibly expensive therapy with no hope. We need to show honesty, and restraint."

8. Use of unreasonably expensive medications for rheumatoid arthritis care before much less expensive therapies have been tried is a big area of potential cost-cutting, Scherger says. "Drugs like Enbrel and Humira will be used way more judiciously."

9. Use of older or no antibiotics instead of newer brand name products to treat common viral infections when there is no evidence of bacterial infection.

10. Inappropriate use of expensive asthma medications, such as inhalers. "The bigger issue is whether the patient has a long-term plan" and knows when to use a controller asthma medication versus a rescue asthma treatment.

11. Screening for prostate specific antigen in men over age 75 is not recommended, and in men younger than 75, there is no good data to suggest screening will save lives.

12. Hip and knee replacements are probably vastly overdone, Wood says.

"Decisions about what is covered today (with taxpayer dollars) is sometimes based on good evidence, and sometimes based on flimsy evidence depending on expert opinions and recommendations from local or state committees," Wood says. And throughout the country, even from one Medicare region to another, there is remarkable variation.

"What we need to do is make it clear to consumers and physicians alike to make sure that everything that is done, needs to be done. Both physicians and their patients should look at the same information and make a decision about that," he adds.

"If the patient opts to undergo a procedure based on shared decision-making, and there's reasonable evidence to say it should help, then it ought to be covered. But if there's little evidence, and the patient still wants it done, then the patient will have to pay more of that expense," he says.

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