

Why do we pay for bad health care?



by IRA BYOCK
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Health care costs are killing us. Experts now talk about the [financial toxicity](#) of expensive treatments for cancers, autoimmune diseases, and chronic viral infections. The sicker you are, the more it hurts. During the American Society of Clinical Oncology meeting this month, doctors [debated](#) whether the advantages of [new treatments](#) for lethal cancers are worth the adverse consequences of their exorbitant costs. Sadly, far too much of our health care spending goes to treatments that have little effect, or that actually harm people.

This brings me to a question that is awkward for a physician to ask: Why do we pay for bad care?

The Institute of Medicine has [defined good care](#) as health care that is safe, effective, timely, equitable, efficient, and patient-centered (customized to the needs and values

of each individual). This definition has given rise to best practice guidelines and measures that health systems, clinicians, oversight bodies, and payers can apply in monitoring the quality of health care services and outcomes.

In the [Choosing Wisely](#) campaign, launched in 2010, more than 50 medical specialty societies have identified practices with unproven benefits, avoidable harms, or unnecessary expenses that doctors and patients should question. It is an opportunity for insurers, Medicare, and Medicaid to apply the medical profession's own guidelines to drive quality improvement.

Not everyone is getting the message. Here are two examples that I've seen all too often in my years practicing palliative care, which aims to improve quality of life for seriously ill people and their families.

Feeding tubes. It was once common practice to surgically place feeding tubes into the stomachs of people with late-stage dementia who had trouble eating. By the late 1990s, solid evidence showed that this did not extend life or improve quality of life. In fact, it often made weak and bewildered people feel anxious and miserable. Slow feeding by hand works far better. The medical associations that represent geriatrics, long-term care, and palliative medicine all recommend [not placing feeding tubes](#) in dementia patients. In some places, like Salt Lake City and Portland, Ore., only about 1 percent of dementia patients get feeding tubes. The national average, however, is 6 percent, and it's more than 12 percent in Los Angeles.

Radiation therapy when cancer spreads to bones. Cancer often spreads (metastasizes) to the bones. When this happens, a single dose of targeted radiation usually alleviates pain and halts local tumor growth. This well-proven approach avoids the disruption of traveling to and from treatment centers to get repeated doses for already frail patients. It's also a lot less expensive. If pain returns months down the line, one additional treatment commonly suffices. Single-dose radiation therapy is recommended by the [American Society for Radiation Oncology](#). It has long been standard practice in Canada and Europe, and is included in [Choosing Wisely](#). Yet most Americans who develop bone metastases are still subjected to multiple doses of radiation therapy, at over [twice the cost](#).

Medicare and insurance companies underwrite both of these ineffective and potentially harmful practices. And there are many more examples.

It isn't profit that drives doctors to prescribe treatments with significant burdens and little benefit. Instead, it is often the persistent assumption, engrained by our medical training, that more is better when it comes to treating serious illness. There is also the

tendency to hope that the patient in front of you will be the exception, the one who will benefit from more [aggressive treatment](#).

Here's one way to fix the problem, particularly for patients with advanced disease: Payers could curtail ineffective practices while simultaneously honoring legitimate medical or religious exceptions and avoiding the specter of rationing by requiring a palliative care consultation or, at the very least, documented conversations between doctors and patients, usually with their families. In these discussions, doctors and patients would decide whether the potential benefits of a proposed treatment are worth the expected burdens and risks. During the [death panel debacle of 2009](#), any proposal to curtail paying for specific disease treatments would have been dead on arrival.

Things are different today. An openness for bold, corrective actions across the political spectrum has been fostered by the overwhelming evidence and, perhaps more important, the painful personal experiences of leaders in government, business, and religion who have witnessed the effects of ill-considered treatments on their own family members.

There is no moral imperative to pay for ineffective or harmful treatments; indeed, there is a moral imperative not to.

Requiring second opinions or prior authorization for high-risk, low-yield procedures would make doctors think carefully about which patients are among the majority who will be harmed and which ones are truly the exceptions. Of course, this would require Medicare and health plan administrators to put into place systems for swift and fair peer review for both prior authorization and appeals.

This is strong medicine. But financial disincentives can work. Since October 2012, when Medicare began modestly penalizing hospitals for [readmitting patients](#) who had been discharged less than 30 days before, readmission rates have fallen. That policy is [not perfect](#) — some repeated hospitalizations are warranted — but the approach is worth refining. Noticeably more attention is now being paid to details of discharge planning, communication, transitions of care, and close follow-up, all of which are good for patients.

Multiple reform strategies will be required to meet the health care needs of America's 21st century population. As we strive to rein in costs, identifying what constitutes bad care and declining to pay for it would send a message that we are serious about quality.

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