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New Yorker Article Sparks Strong Reaction

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By **Jenny Gold and Kate Steadman**
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Until recently, McAllen, Texas, a quiet border town, was best known for being the backdrop of the film "Lonesome Dove." But an article recently published in the *The New Yorker* has brought the town unwelcome notoriety: McAllen is now synonymous with wasteful medical spending.

New Yorker staff writer Atul Gawande--a veteran of the Clinton administration's health reform efforts, a surgeon at Brigham and Women's Hospital in Boston and author of the book "Complications, A Surgeon's Notes on an Imperfect Science"--visited McAllen to find out why it is one of the most expensive health care markets in the country, second only to Miami. McAllen spent more than \$15,000 per Medicare enrollee in 2006, which is almost twice the national average and \$3,000 more than the average McAllen resident earns in a year. Yet despite the extra spending, the quality of care is below the national average.

After speaking with doctors and hospital administrators, Gawande determined that "the primary cause of McAllen's extreme costs was, very simply, the across-the-board overuse of medicine." Doctors there prescribed more tests and performed more operations than average but had poorer results. In other words, more health care spending does not mean better quality. Gawande offers the Mayo Clinic and the community of Grand Junction, Colo., as examples of the opposite scenario--lower health care spending yielding better quality.

The resulting article is now being called one of the most influential health care stories in recent memory. The *New York Times* reported that President Obama made it required reading for his staff and cited it at a meeting with Democratic senators last week. His budget chief, Peter Orszag, has written two blog posts about the article. Health and Human Services Secretary Kathleen Sebelius referred to it in a speech at the John F. Kennedy School of Government last week. Lawmakers on the Hill also are discussing it. Congressman Jim Cooper, D-Tenn., for instance, says the article has "shifted perceptions on the health care industry."

We spoke with health experts, media critics and a local physician, to explore why the article has had such impact and what they think about Gawande's conclusions.



Robert Blendon
Professor of Health Policy and Political Analysis, Harvard School of Public Health and John F. Kennedy School of Government

It's a very powerful article in that it explained in ways that I've never seen before the issue about how some communities appear to use more hospital care, physician care, lab tests than [others]... and why that's such an important issue when you think about the issue of containing costs in the future.

The fact that the front of the *New York Times* had the president reading and discussing the article with his budget director leads me to believe the article could affect health reform.

What's critical is this research--work has been done for over two decades and has not caught the consciousness of leading public figures involved in reform. It's an issue they occasionally talk about but it's very hard because it sounds very abstract. What Dr. Gawande's article did was make it so real that people who are elected public figures can talk about this issue to anyone they meet.

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I think in terms of the influence of a single article, this is one for the record. I have not seen a single article quoted by so many figures that affected how they thought about the issue. Everybody I talk to from Washington says that someone they met has been talking about that article. [It] made it possible for people to discuss this issue.



Greg Scandlen
Senior Fellow, Heartland Institute

Statistics can mislead as well as inform. I think that's a lot of what's happening here. If it is the case that there is a physician shortage and therefore people go to the ER, then sure. But using Medicare claims as a way of evaluating the quality of medical practice around the country is itself misleading [because] the numbers are looking at all Medicare [beneficiaries] so everyone on the program is covered.

This notion that it's physicians and hospitals that are tricking people into over-consuming is insensitive at best. Physicians and hospitals do what they're asked to do by their patients. I think that kind of phenomenon completely escapes statisticians. It would be a fascinating study to actually spend time with the folks there and find out what's on their minds. Ultimately health care is about people, and analysis that avoids talking to folks is a poor analysis.

Now [Gawande] did talk to and spend a lot of time with a lot of providers and hospital administrators. But his remedy--that everyone should be like Mayo--misses the point as well. The problem is that Mayo and Cleveland Clinic are outstanding [and] while [these programs] should be held up as ideal, the notion that the entire country is going to be ideal just like those guys are is nonsense. They still get paid through Medicare. They still get paid through private health insurers. It's clearly not the payment system that's causing them to be great. We've done salaries before and HMOs. The concern is it provides an incentive to undertreat. HMOs in the '90s were solidly rejected by the American people for this very reason. Overtreatment is only half the story. There's also a problem of undertreatment. Salaries are not some magical panacea.



Joseph W. Stubbs
President, American College of Physicians
Primary Care Physician, Albany, Ga.

The real challenge as a primary care physician is convincing patients that over-treatment is not the same as state of the art treatment. That's a key problem. Patients seem to feel if you're not necessarily recommending the newest imaging test like an MRI or a CAT scan or you're not referring them to a specialist, that you're just trying to save money. Instead, we're trying to say good care can be done without those things. It can be done by some common sense things that are more low cost. Trying to see how something works before jumping in and doing high cost procedures is a good thing.

The three things I think would help us do things better, and more like Grand Junction as opposed to McAllen, Texas, is that one, we change the reimbursement system to incentivize value instead of volume.

The second is we need to increase our base of primary care physicians. What was not said in that article, but what goes along with it, is if you look at places across the country where there's a greater ratio of primary care physicians to specialists then the cost goes down and the quality goes up.

The third thing is the ability to communicate with each other through health information technology. We are still way behind in terms of not only using computerized records and health IT but the ability to transfer information about a patient to the hospital or to a specialist who has seen the patient. They might order a test that's already been done or look for a disease that's already been ruled out.



E. Linda Villarreal
Past President of the Hidalgo-Starr County Medical Society
Internist in Edinburg, Texas

I've got several copies and believe it or not, I read two hoping it would change. [Other doctors and I] read this and said we need to do something, we need to respond... Even though a lot of what he said was true, there's a lot that he didn't say that would actually balance the story.

There are many primary care physicians who are practicing good medicine down here. I don't think he spoke with any of them. [Some doctors are overprescribing] but it's not 100%. There are physicians that are doing self-referrals--they own radiology facilities and they order more radiology tests or they have an interest in a lab so they order more labs. Yes, that does exist. But it's not global.... I do believe there are physicians who perhaps are looking at other business ventures and profits first and then patient care second. But it is a very small percentage of the physician population in the valley. I believe he was erroneous in simply utilizing one specific physician population or specialty because I did not identify or recognize any comments by primary care doctors who perhaps do not have financial investments in hospitals and simply are trying to work as physicians and care more about what they do than what they get paid.

This morning I woke up and thought, wouldn't it be nice if I could send President Obama a note saying meet me for tea so I can tell you what it's really like? Because it's sad that they're going to use that unilateral bunch of facts and fiction to decide how health reform should be approached in this area. That would really upset me even more than the article.



Gary Schwitzer
Associate Professor, University of Minnesota School of Journalism and Mass Communication

The article was captivating. I am not surprised at the amount of attention the piece has received. The viral spread of this was amazing, and again it should have been. But none of the basic information in this article is new.

[Gawande] didn't have garden variety interviews, he had excellent perspectives. It's not like the Dartmouth Atlas work has been under-covered or underappreciated by journalists. It probably is one of the most covered themes year in and year out. But Gawande put names and faces and appropriate roles behind the stories. No matter where you live in this country, there is a story in the Dartmouth Atlas data.

There was a powerful and important message there for everyone in health journalism--especially young reporters, maybe older, more frustrated reporters too--that the beauty of that piece is the collection of perspectives and the storytelling he was able to weave through the narrative. It didn't require breaking news, a new study or new data.

The enticing--and it shouldn't be intimidating--aspect is he didn't do anything that anyone couldn't do. Health reporters spend too much time thinking about breakthroughs, cures and new stuff, and not enough on access, disparities and variations in policy. People often come back to me arguing 'that stuff doesn't sell'--well, read Gawande's article. I think articles like this have a life for a long time. I think people will have it in their file drawers (or virtual file space) for many years.

You can read Atul Gawande's article, "The Cost Conundrum", [here](#).