Ten percent every year, for more than 40 years. That would be an outstanding rate of return on investments in any stock market. But actually, it’s our country’s annual rate of increase in spending on health care. And many have questioned whether it’s an investment that’s paid off. Have we really gotten our money’s worth?

This year, a pair of U-M General Medicine faculty and their Harvard University colleague attempted to answer that question. Allison B. Rosen, MD, ScD, Sandeep Vijan, MD, and Harvard economist David M. Cutler, PhD, analyzed just what Americans have gotten for their ever-increasing spending on health care, and how it has changed over time.

In the August 31 issue of the New England Journal of Medicine, they gave their answer: Yes, on average, the spending has been worth it. But the rate of return on our investment is slowing down, especially among older people.

First, the good news: With the rise in health care expenditures have come continuous increases in Americans’ life expectancy. Today’s newborns are expected to live seven years longer than 1960s babies, and each of those added years carries an average cost of $19,000 per person in today’s dollars.

In other words, the nation is getting reasonable health improvements for the money spent, since more years of life translates to more years of participation in the economy, the family and the social structure. Even though the number of dollars needed to gain an extra year of life has risen from $7,400 in the 1970s to more than $36,000 today, this is still a decent investment. Far fewer Americans smoke, vaccines and seatbelts protect nearly everyone, and new drugs and technologies mean we’re able to treat and even cure serious illnesses and injuries that once killed thousands.

Now, the bad news: The “low-hanging fruit” has been picked, and now we must better focus our spending on the things that give the most value.

As a result, the analysis found, the increased cost of caring for people over age 65 is providing diminishing returns, with the increases in cost outpacing the rate at which older people are gaining years of life. In the last decade, it cost $145,000 to “buy” an additional year of life for the average 65 year-old, a much higher cost than for younger people. And forecasts show that health care spending will continue to outpace gains in longevity.

So, the next step is to maximize the use of health strategies that we know can help patients—but that many patients never receive for reasons of cost, access or inefficiency.
In fact, say the researchers, the overall “good value” of health care spending masks a wide variability in the value of the actual health services that Americans purchased.

Spending large amounts to pay for the aftermath of a stroke or kidney failure, for example, gives much less value for the dollar than paying for inexpensive medicines that can help a person with diabetes lower their risk of stroke or kidney damage. And if many diabetes patients aren’t taking those medications regularly, it’s worth it to find out why, and to take steps to help more of them—for instance, taking those medications regularly, it’s worth it to find out why, and to take steps to help more of them—for instance, by reducing their cost. That philosophy is what drives the work of the Center for Value Based Insurance Design, headed by the Division’s Mark Fendrick, MD.

It’s also the idea behind a unique benefits project announced in 2006 by the University, which is providing certain medications for free or at reduced cost to employees who have diabetes. Called MHealthy: Focus on Diabetes, the project will yield more data for Rosen and others to study, in their continuing effort to find out how Americans can get more value for their health care dollars.
Better Care at the End Of Life—for Everyone

The way Americans die has changed greatly in recent years, with more patients receiving hospice or palliative care from specially trained physicians and nurses. But insurance reimbursement policies still hamper the process, and there aren’t enough specialists in end-of-life care to meet the growing demand.

The answer to this situation may lie with the very primary-care physicians who already oversee most patients’ care. This year, Maria Silveira, MD, MPH (left) and her colleagues reported the results of a focus group study of Michigan primary care doctors. They found that most primary care physicians feel they can take the lead on end-of-life care, so long as they operate within a healthcare system that gives them the continuity, time, care-coordination support, and information-sharing they need to do the job. This work, sponsored by the Robert Wood Johnson Foundation and a Veteran’s Administration Career Development Award, won Dr. Silveira the Outstanding Young Investigator of 2006 Award from the American Academy of Hospice and Palliative Medicine. To explore this issue further, Dr. Silveira plans a national survey of primary care physicians in 2007.

At the same time that Dr. Silveira is examining ways to provide end-of-life care through the existing system of primary care, she is also looking at ways to broaden the availability of hospice care.

Working on the belief that many patients do not use hospice because they cannot find ones that provide expensive services such as palliative chemotherapy or radiation, Dr. Silveira led a statewide survey of hospice operating practices in conjunction with the Michigan Hospice & Palliative Care Organization. It showed that there is wide variation in services and admission criteria across hospices in Michigan. As a result of this study, sponsored by a grant from the Munn Foundation, hospices across the state are working together to broaden the range and quality of services they offer to Michigan’s dying patients. Dr. Silveira plans to repeat this study nationally in the coming year. In addition, she and division chief Laurence McMahon Jr, MD, MPH, plan to investigate how the location of hospices affects the use of hospice by ethnic minorities and the poor.

Because Medicare and Medicaid pay for most hospice and palliative care in America, and because state and federal oversight are key factors, Silveira is working in the public-policy sphere as well as the research arena. This year, she was named to the state Committee on Pain and Symptom Management by Michigan Governor Jennifer Granholm, and was made a member of the American Academy of Hospice and Palliative Medicine’s Committee on Public Policy.

Doctors in the House

For ten years, the U-M Health System has been on the leading edge of one of the hottest trends in hospital care: the hiring of doctors who base their practice entirely within the inpatient floors of a hospital.

These specialists, called hospitalists, are trained in general internal medicine but have a special focus on managing the multiple needs of hospitalized patients. They have come to the fore at U-M and nationwide in recent years, with 27 now on faculty at Michigan, 15,000 currently in practice in the U.S., and the number expected to double in the next few years.

The hospitalist trend is fueled by many factors: the rise in numbers of patients, the time and resource pressures facing other physicians, caps on the numbers of medical residents that hospitals can hire and the hours they can work, and hospitals’ desire to improve care, prevent complications and move patients to less-acute care settings as soon as possible.

At U-M, General Medicine faculty working full- or part-time as hospitalists staff six inpatient resident teams and one large non-resident team, which was created to reduce the number of patients on the resident services. Collectively, these teams treat just under 7,000 patients each year—up from five faculty and 2,000 patients in 2003. They’re led by Scott Flanders, MD, director of the hospitalist program and associate division chief for inpatient programs, and Vikas Parekh, MD, assistant director of the hospitalist program.

In addition to providing excellent care to patients with a broad range of conditions, the U-M hospitalists have emerged as instrumental factors in making hospital care better for all U-M patients.

They’ve partnered with surgeons to create a pre-operative clinic and post-operative management protocols that seek to optimize a patient’s experience during and after surgery. They’re working closely with the hospital’s Infection Control & Epidemiology team to pinpoint and eliminate potential sources of hospital-acquired infections.

They’re also leading a regional patient-safety program that involves nine hospitalist groups around metro Detroit and is funded by the Blue Cross Blue Shield of Michigan Foundation. That project, called Hospitalists as Emerging Leaders in Patient Safety or HELP5, and led by Flanders and Sanjay Saint, MD, MPH, is pooling the knowledge and best practices of hospitalists in order to reduce medical errors, and prevent infections and other problems.

This year, the U-M hospitalist program launched the SHARP project, whose name stands for “Specialist-Hospitalist Allied Research Program.” Funded by a grant from the Department of Internal Medicine, the program is teaming hospitalists with specialists to facilitate research projects of all kinds. SHARP’s pilot projects combine the division’s health-services research strength with the inpatient expertise of the hospitalist faculty.

For instance, Flanders, Saint, Parekh and chief hospital infection-control officer Carol Chenoweth, MD, MS, of the Infectious Disease faculty, are joining forces to study how best to prevent false-positive blood infection test results—a major problem that keeps many patients in the hospital and on antibiotics for no reason. Another example teams hospitalists with cardiologists to analyze the factors that influence patients’ tendency to suffer—and survive—a cardiac arrest during their hospital stay.

Further studies are now in planning stages, as the U-M team takes its place as one of the largest academic hospitalist services in the country, and one of the most active in research to improve patient care.
Director of the hospitalist program, Dr. Scott Flanders (foreground) with his team of hospital specialists, who together improved the care of almost 7,000 patients this year in University Hospital.