

P E R S P E C T I V E

Exceptionalism Or Extravagance? What's Different About Health Care In South Florida

Physicians' behavior seems to outweigh patients' preferences for care in South Florida, especially in the last six months of life.

by Jonathan Skinner and John E. Wennberg

ABSTRACT: In posing the “puzzle” of Florida exceptionalism, Victor Fuchs raises fundamental questions about Medicare’s efficiency and equity. We agree that the higher spending in Florida has little to do with lower mortality rates. However, physicians and hospitals do play a large role in making South Florida different. Miami physicians are not more generous in providing heart, hip, or back surgery, procedures that beneficiaries seeking an active lifestyle might want. Instead, end-of-life care makes Miami truly exceptional: Patients in their last six months of life see more physicians and spend more time in intensive care than is the case virtually anywhere else in the world.

IS HEALTH CARE in Florida really different from care in the rest of the country? Victor Fuchs answers in the affirmative, and in his thought-provoking paper poses two additional questions: Why is health care spending so much higher in Florida? And why are mortality rates lower? Even within Florida, Fuchs shows that the degree of exceptionalism seems to grow the further south one travels, which suggests that Key West must be the most expensive and healthiest city on the planet.

The paper presents Florida as an intriguing puzzle, but Fuchs is really asking fundamental questions about the efficiency and equity of the U.S. health care system, and the Medicare program in particular. What leads regions such as Florida, but also in many other areas of the country, to spend so much more on health care than other parts of the country? Residents

in some parts of Florida can expect roughly \$40,000 in Medicare benefits over their lifetime in excess of the taxes they pay in, money that will come largely from taxpayers who live outside of Florida.¹ What accounts for this huge difference in spending relative to low-cost regions such as Minnesota and Oregon, and what do Floridians get in return for all of this medical spending? These two questions are at the heart of meaningful health care reform, and yet they often are ignored because the answers are either difficult to accept or politically unpopular.

■ **Higher spending levels.** First, what factors might have caused the higher levels of spending in Florida, particularly South Florida? Fuchs discounts the importance of “supplier-induced demand,” where a larger population of physicians in Miami simply look for and recommend more procedures to their

Jon Skinner (jonathan.skinner@dartmouth.edu) is the John French Professor of Economics and a senior research associate at the Center for the Evaluative Clinical Sciences, Dartmouth Medical School, in Hanover, New Hampshire. Jack Wennberg directs the center and is the Peggy Y. Thomson Professor of the Evaluative Clinical Sciences at the medical school.

patients, even if the physician knows that these procedures aren't particularly beneficial. We share his skepticism of this traditional construct, in which physicians make trade-offs between "quality of care" (however defined) and take-home income. It is no more expensive to live in Miami than in other large cities, nor does Miami have an unusually high physician-to-population ratio. New Haven, Connecticut, and Napa, California, among other regions, both have higher ratios.² Instead, Fuchs's preferred explanation is that people who enjoy a healthy outdoor existence tend to move to South Florida, where they share an avid interest in getting lots of health care along with their exercise. They survive longer not because of the health care, of course, but because of the exercise.

We end up with the same conclusion: that the extra spending doesn't reduce mortality. But we get there along a different path. In particular, we believe that physicians, along with willing hospitals, are at the root of Florida exceptionalism. But we also acknowledge that physicians' behavior does not operate in a vacuum. Patients in Miami come to expect full-bore health care as the norm, and they worry when they can't see multiple specialists or if they're not provided with an array of diagnostic tests. Although this could create problems in unraveling which came first, physicians' opinions or patients' beliefs, we provide evi-

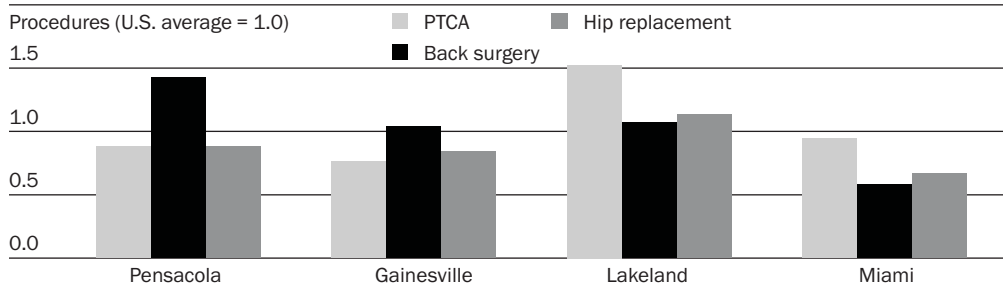
dence below suggesting that the primary driver of Florida exceptionalism comes from the shared beliefs of health care providers in the region that more health care for the chronically ill means better health care.³

We use data from the *Dartmouth Atlas of Health Care* to consider the Florida puzzle.⁴ It should be kept in mind that these data are not directly comparable to the Fuchs data, for several reasons. First, the time frame is different; we use 1995–1996 data, while Fuchs uses 1990 data. Second, there is incomplete geographical overlap between the metropolitan statistical areas (MSAs) used by Fuchs and the hospital referral regions (HRRs) used in the atlas. Third, the sample of elderly patients is different, as Fuchs restricts his data to whites ages 65–84, while the atlas data extend to age 99 for all races, with indirect adjustment on the basis of age, sex, and race.⁵ Comparisons corresponding to the three regions that Fuchs has designated as the lowest-cost areas (Pensacola, Gainesville, and Lakeland) and Miami are shown in Exhibits 1 and 2 for several categories of care, in which rates are shown as ratios relative to the U.S. national average.⁶

Under the hypothesis that Medicare enrollees are eager to receive the latest in health care technology designed to preserve their active lifestyles, one might expect preference-sensitive surgical procedures such as hip replacements, back surgery, and angioplasty to

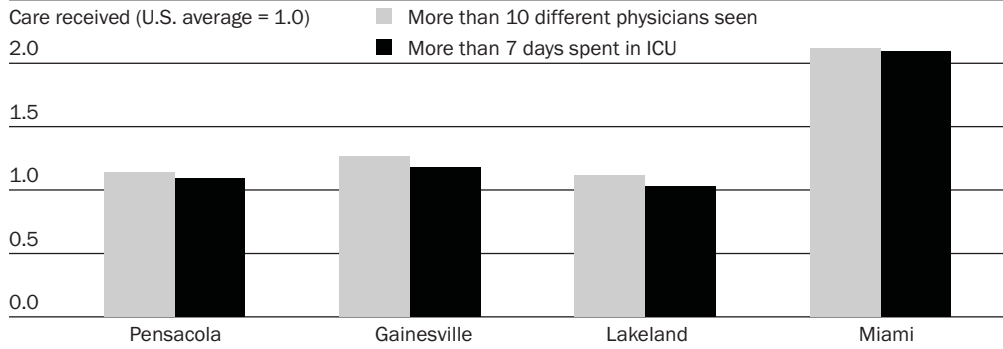
EXHIBIT 1

Surgical Procedures Performed In Four Florida Regions, Relative To The U.S. National Average, 1995–1996



SOURCE: J.E. Wennberg and M. Cooper, eds., *The Quality of Medical Care in the United States: A Report on the Medicare Program*, Dartmouth Atlas of Health Care in the United States 1999, www.dartmouthatlas.org/atlaslinks/99atlas.php (14 July 2003).

NOTE: PTCA is percutaneous transluminal coronary angioplasty.

EXHIBIT 2**End-Of-Life Care (Last Six Months Of Life) In Four Florida Regions, Relative To The U.S. National Average, 1995–1996**

SOURCE: J.E. Wennberg and M. Cooper, eds., *The Quality of Medical Care in the United States: A Report on the Medicare Program*, Dartmouth Atlas of Health Care in the United States 1999, www.dartmouthatlas.org/atlaslinks/99atlas.php (14 July 2003).

NOTE: ICU is intensive care unit.

be higher in Florida, and particularly South Florida.⁷ By “preference-sensitive,” we mean that there are both risks and benefits involved with these surgical procedures and that reasonable people may differ with regard to the desirability of these procedures.⁸ As Exhibit 1 shows, however, there is no clear pattern with regard to these preference-sensitive surgical procedures, with regard to either the national averages (represented by 1.0 on the vertical axis) or regions in Florida. If anything, rates of these procedures seem to be lower in Miami than in the other Florida regions and even the United States as a whole. In other words, residents of Miami don’t appear to be receiving any more surgical procedures such as hip replacements that should most reinforce and enhance an active lifestyle.

Exhibit 2 shows two measures for the intensity of care among people in their last six months of life: the percentage of patients spending more than seven days in an intensive care unit (ICU) and the percentage of patients seen by more than ten distinct physicians. Once again these figures are shown relative to the U.S. national average. Here the contrast is quite stark: The three low-cost Florida regions are slightly higher than the U.S. national average, while Miami stands out as an outlier, with more than double the national rates. We be-

lieve that these patterns suggest that physicians’ beliefs about how intensively to treat chronically ill patients (many of whom are in their last six months of life), rather than patients’ preferences, are the driving force. That is, it seems unlikely that being seen by more than ten physicians is more important to residents of Miami than is getting a hip replacement to improve their tennis game.

■ **Mortality levels.** We agree with Fuchs’s views on why mortality is lower in South Florida. The lower mortality rates could be related to better social networks; indeed, we also find very low mortality rates in the Sun City, Arizona, HRR, which has a very large proportion of elderly residents. We also think it unlikely that the higher levels of health care use have contributed to the lower mortality. Two recent papers suggest that higher levels of spending intensity are associated with no better survival, satisfaction with care, or access to health care providers.⁹ We do disagree, however, with the suggestion that it is premature to draw any inference for policy. On equity grounds, we have problems with the idea of single working mothers in Nebraska (often themselves lacking health insurance) footing the bill for gold-plated health care provided to high-income Medicare enrollees in Miami. On efficiency grounds, why should Medicare con-

tinue to pay billions of dollars every year on health care that does nothing for longevity, nothing for patient satisfaction, and nothing for better access to care?

.....
The authors are grateful to the Robert Wood Johnson Foundation and the National Institute on Aging (Grant no. PO1 AG19783) for financial support.

NOTES

1. D. Feenberg and J. Skinner, "Federal Medicare Transfers across States: Winners and Losers," *National Tax Journal* (September 2000, Part 2): 713-732.
2. J.E. Wennberg and M. Cooper, eds., *The Quality of Medical Care in the United States: A Report on the Medicare Program*, Dartmouth Atlas of Health Care in the United States 1999, www.dartmouthatlas.org/atlaslinks/99atlas.php (14 July 2003).
3. For example, one recent study found Florida exceptionalism with regard to oncologists' and urologists' recommendations for prostate-specific antigen (PSA) testing, the use of brachytherapy, and androgen deprivation use. In Florida 67 percent of radiation oncologists recommended routine PSA screening for men over age eighty, compared with 35-45 percent in other parts of the country. (Screening among this population is controversial, since it can take up to a decade following the PSA test before there are detectable manifestations of prostate cancer, so that men over age eighty are more likely to die of something else.) M.M. Collins et al., "United States Radiation Oncologists' and Urologists' Opinions about Screening and Treatment of Prostate Cancer Vary by Region," *Urology* (October 2002): 628-633.
4. Wennberg and Cooper, eds., *The Quality of Medical Care in the United States*.
5. The price adjustment method also differs. Ibid.
6. While Fuchs also found Sarasota and Fort Myers to be high-cost regions, our data do not yield the same degree of Florida exceptionalism. (West Palm Beach is not an HRR, so we do not include it as a comparison area.) Both the atlas and the Fuchs data are in agreement regarding the high cost of Miami health care, so we focus just on Miami as the quintessential high-cost region.
7. Percutaneous transluminal coronary angioplasty (PTCA) within twenty-four hours of the onset of acute myocardial infarction (AMI) is an effective treatment that should not generally entail trade-offs for the patient, but only less than 10 percent of the total number of angioplasties performed are PTCA. Most are performed to relieve symp-

toms of ischemic heart disease.

8. See J.E. Wennberg et al., "Geography and the Debate over Medicare Reform," 13 February 2002, www.healthaffairs.org/WebExclusives/Wennberg_Web_Excl_021302.htm (14 July 2003).
9. E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* (18 February 2003): 283-287; and E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* (18 February 2003): 288-299.