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An Analysis and Response to President Obama's
Health Care Reform Address to the American Medical Association
Part I
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On June 15, 2009, President Obama spoke to the American Medical Association on health care reform. I have read the released copy of his address but did not hear it delivered. There is a great deal to be admired in what he said. Every American, I believe, should applaud the principle that healthcare is a right and that no American should be denied access to healthcare. The problems come with the "how" and with the "how much." On the same day that the President spoke to AMA, Jeffrey A. Miron, a senior lecture in economics at Harvard University released a statement in which he said, "Increased efficiency in health care is indeed possible, but assuring 'high quality, affordable care for every American,' as the administration seeks to do, is not." The President says it can be done and will be done; experts say that it can't. Both cannot be right.

While there is an established role, at least since Medicare legislation in the mid-1960s, for the Federal Government in healthcare, the question is how far does that responsibility go and how far can the Federal government intrude into the private lives of individuals in fulfilling that responsibility?

The Salient Elements of the President's Address

After a review of alarming evidence that healthcare costs are a threat to the economic future of the United States which, as the President inferred should cause everyone anxiety and fear, he tried to assuage the fear that his intent is to "socialize medicine," or that he was going to accomplish reform by having healthcare providers of all types – physicians, hospitals, other ancillary care givers – pay for it with reduce reimbursement for the services they perform. The reality is that that is exactly what his plan calls for.

The President identified the steps which are necessary in order to make healthcare reform work:

1. "…upgrade our medical records by switching from a paper to an electronic system of record keeping."
2. "…cutting down on junk food that is fueling an epidemic of obesity…"
3. "Building a health care system that promotes prevention rather than just managing diseases."
4. "Our federal government also has to step up its efforts to advance the cause of health living."

As we shall discuss, none of these efforts have proved yet that they will result in cost savings. And, it is problematical for most Americans in thinking that it is the Federal Government's responsibility to "make" us be healthier. Also, while preventive healthcare is its own reason for existence, it has not yet been proved that preventive healthcare will, in the short run, reduce healthcare costs. In fact, experience proves that in the short run, increased preventive care will dramatically increase costs and, if in the long run, it reduces cost, the payoff of that reduction may be a generation away.

As a case in point, I estimate that the first year cost of a major initiative to immunize all SETMA's patients with age-appropriate immunizations will cost in excess of $600,000. While this is important and while we are promoting and aggressively pursuing this program, the payoff will be a long time coming and it will be difficult to quantify and even more difficult to associated savings directly with this accelerated immunization program.

The President, continuing to advocate the Federal Government accepting responsibility for individual, personal behavior, said, "Our Federal government also has to step up its efforts to advance the cause of healthy living." He added that the five costliest illnesses – cancer, cardiovascular disease, diabetes, lung disease and strokes – can be prevented. He denied that these illnesses and their causes are a function of an aging population. This last statement is contradicted by scientific evidence.

President Obama references the article in the June 1, 2009, New *Yorker Magazine* which was entitled, "What a Texas town can teach us about health care." Every American should read this article. It is, as the President said, a case study in what is wrong with high tech, high utilization healthcare. He also addressed the Dartmouth study which documented that more care and more expensive care is not associated with improved health care. That study was summarized in *Your Life Your Health*, May 14, 2009. It can found at www.jameslhollymd.com. The President is absolutely right; expensive and excellence are not synonyms.

Structural Changes needed in healthcare

The first structural change the President identified was that reform must begin with how providers are compensated. I agree. However, when he speaks of "bundl(ing) payments," all physician know that is Washington-code for decreasing revenue to physicians while allowing a rapid increase in their costs, in the demands placed upon them and in this President's plan in the taxation on what income they have left.

Within this structural change, the President hopes to encourage more medical students to choose primary care as a career. *Your Life Your Health*, May 19, 2009 was entitled, "Healthcare Education and Delivery: Essential Changes Needed in Both." This article introduces some of the concepts from *Innovator's Prescription: A Disruptive Solution for Health Care* By Clayton M. Christensen to discuss how medical education must be changed in order to meet the demands of 21st Century healthcare delivery. Those changes do not only deal with what area a student chooses in which to concentrate, but

more importantly how that medical student interacts with other members of the healthcare team: nurses, pharmacies, dentists, and other allied health professionals.

The second structural change the President addressed is in regard to the availability of the quality of medical information at the point of care. I agree. That is the greatest value of medical informatics, i.e., computers in healthcare. It is possible to bring to bear upon a healthcare encounter not what each individual provider knows but what is known. For instance, each year the American Diabetes Association publishes a 100-page update on the standard of care in diabetes. It is possible for every primary care provider to read, digest and recall, while seeing a patient, all of this information. But, when a medical group like SETMA uses electronic patient records and when that group develops a state-of-the-art disease management tool for diabetes, which SETMA has, it is possible continually to update that disease management tool and thus make sure that all providers are measuring their performance by the best evidence-based standard there is.

In addition, it is possible to audit the performance of providers in order to let them know how their performance compares with their colleagues. In *Your Life Your Health*, January 1, 2009, SETMA published our data for diabetes care over the past 9 years. Essentially that report, which can be reviewed at www.jameslhollymd.com , showed that SETMA's treatment of diabetes has steadily and consistently improved. Without electronic patient records and without data analysis we would not have known that.

In this part of his address the President said, "a recent study, for example, found that only half of all cardiac guidelines are based on scientific evidence." Physicians who think about healthcare policy have said this for years. Too often, new and expensive technologies are embraced without any proof that they improve the quality of care, the quality of outcomes, or that they positively affect the cost of that care.

In *The New Yorker Magazine* article referred to above the following is reported:

> "Some were dubious when I told them that McAllen was the country's most expensive place for health care. I gave them the spending data from Medicare. In 1992, in the McAllen market, the average cost per Medicare enrollee was $4,891, almost exactly the national average. But since then, year after year, McAllen's health costs have grown faster than any other market in the country, ultimately soaring by more than ten thousand dollars per person.
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> "'Maybe the service is better here,' the cardiologist suggested. People can be seen faster and get their tests more readily, he said. Others were skeptical. 'I don't think that explains the costs he's talking about,' the general surgeon said.
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> "'It's malpractice,' a family physician who had practiced here for thirty-three years said. 'McAllen is legal hell,' the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere. That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering

> awards at two hundred and fifty thousand dollars. Didn't lawsuits go down? 'Practically to zero,' the cardiologist admitted.
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> "'Come on,' the general surgeon finally said. 'We all know these arguments are (expletive deleted). There is overutilization here, pure and simple.' Doctors, he said, 'were racking up charges with extra tests, services, and procedures.'"

This is unusual candor; but it is a fact. And, it is true in areas other than in McAllen. The only way to change this behavior is to stop rewarding it. The President is right about this, but he must be careful about how he tries to do it.

The July 1, 2008 *Consumer Reports* contained an article entitled, "Too much treatment? Aggressive medical care can lead to more pain, with no gain." The following was reported:

> "For many consumers and their doctors, good health care means seeing as many specialists as you want. It means undergoing rounds of diagnostic tests, such as CT scans, to make sure everything is going well. And when you're seriously ill, it means prolonged hospital stays and every conceivable treatment.
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> "Though the idea that more health care is better seems to make intuitive sense, recent research has shown that none of the above necessarily helps you live better or longer. In fact, too much medical care might shorten your life.
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> "Those findings grew out of the 2008 Dartmouth Atlas of Health Care study and almost three decades of research by John E. Wennberg, M.D., and colleagues at Dartmouth Medical School (available at www.dartmouthatlas.org). Their 2008 Atlas study of 4,732,448 Medicare patients at thousands of hospitals in the U.S. from 2001 through 2005 found tremendous variation in the way people with serious illnesses such as heart failure and cancer were treated during the last two years of their lives. Some regions used two or three times the medical and financial resources than others."

Consumer Reports summarized the most dramatic findings of the Dartmouth study:

> "…patients with serious conditions who are treated in regions that provide the most aggressive medical care—have the most tests and procedures, see the most specialists, and spend the most days in hospitals—don't live longer or enjoy a better quality of life than those who receive more conservative treatment.
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> "Patients treated most aggressively are at increased risk of infections and medical errors that come from uncoordinated care (such as two doctors prescribing the same drug or

clashing ones). They also receive poorer-quality care, spend a lot more money on co-pays, and are least satisfied with their health care, the Dartmouth research has found.

"The Dartmouth study by John E. Wennberg, M.D., and Elliott S. Fisher, M.D., found that extra care didn't lead to better results."

Consumer Reports continued:

"The amount of medical care that people get for serious illnesses varies enormously from place to place. In the last two years of life, the average patient spent 11 days in the hospital in Bend, Ore., and 35 days in Manhattan. In those same two years, patients visited the doctor an average of 34 times in Ogden, Utah, and 109 times in Los Angeles.

"The Dartmouth Atlas based those findings on Medicare claims records of millions of patients who died from (in order of prevalence) congestive heart failure, chronic pulmonary (lung) disease, cancer, dementia, coronary artery disease, chronic kidney failure, peripheral vascular (circulatory) disease, diabetes with organ damage, and severe chronic liver disease. Together those ailments account for about 90 percent of deaths of people older than 65.

"Over the years, Dartmouth research has yielded some startling insights:

- The local supply of doctors and hospitals has more influence on the amount and type of care that patients receive than their actual medical conditions have. The more medical resources a region has, the more aggressive the treatments are.
- In the regions that deliver the most care, patients have a slightly higher death rate than patients with the same conditions treated in areas that treat less aggressively.
- Patients treated most aggressively are no more satisfied with their care.
- The cost differences are vast. Average Medicare spending over the last two years of life for all hospitals ranged from a high of $181,143 in Manhattan to a low of $29,116 in Dubuque, Iowa.

"A key question, of course, is whether patients are being kept alive longer in the regions that spend more money and deliver more aggressive care. To judge survival, you have to look at people who are similarly ill and then follow them forward over time,' says Elliott S. Fisher, M.D., Wennberg's longtime research collaborator. 'And we've done that.' Their study of 969,325 Medicare beneficiaries hospitalized nationwide for three common conditions—colon cancer, heart attack, and hip fracture—published in the Feb. 18, 2003, issue of the Annals of Internal Medicine,

> analyzed the follow-up tests and treatments the patients received for up to five years after their very similar initial treatment.
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> "Patients in the highest-spending areas received 60 percent more treatment than those in the lowest-spending areas, but the extra care didn't seem to help at all, and it made some things worse. Patients in the high-spending, aggressive-care regions waited longer in emergency rooms and doctors' offices than patients in lower-spending regions did. They were less likely to get recommended preventive treatments, such as aspirin to prevent future heart attacks, or appropriate immunizations. They were slightly more likely to die, and those who didn't die weren't any better off in terms of their ability to function in daily life. And overall they were no more satisfied with their care."

This covers six pages of the President's twelve-page address. Next week, we will examine the second half of his report. Healthcare reform is coming. There is a drive within medicine to change with such innovations as Medical Home and with providers measuring their own performance based on evidence-based medicine. The radical surgery planned by the President upon healthcare is exposed by those who are advising him, even with his conciliatory words. The United States healthcare system does not need radical surgery; it needs aggressive medical management to use a healthcare delivery metaphor.

This discussion is an imperative one; the conclusions are critical.