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Can More Care Provide Less Health?
By James L. Holly, MD
Your Life Your Health
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May 11, 2009, Parija B. Kavilanz, CNNMoney.com senior writer, summarized news reports about President Obama's efforts to get stakeholders in healthcare to agree to cut cost. His report in part stated:

> "Advocating preventive care and streamlining administrative costs are among the steps being promised by the health care industry to help cut $2 trillion in health care expenses over the next decade.
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> "'What's brought us all together today is a recognition that we can't continue down the same dangerous road we've been traveling for so many years, that [health care] costs are out of control, and that reform is not a luxury that can be postponed, but a necessity that cannot wait,' Obama said at a White House event with representatives of the trade groups.
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> "Among the groups, the Service Employees International Union (SEIU), which represents 110,000 nurses and 40,000 doctors…'(is) committed to creating a new American healthcare system by increasing efficiency of care without sacrificing quality of care, and creating a system of wellness, where we now have a system of illness…'"

On Monday, I responded to this reporter and said:

> "I read your story about healthcare savings with interest. I am the CEO of a medium size multi-specialty practice which provides care to the neediest of our community. We are actively remodeling our practice to reflect the vision of Medical Home and its extension into a Medical Neighborhood.
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> "Our practice measures each clinic visit by multiple evidence-based quality indicators: HEDIS, NCQA, NQF, PQRI and Physician Consortium for Performance Improvement. In July, we will begin publicly reporting our performance on these measurement sets.
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> "One of the hopes which the President voices is that preventive care will reduce the cost of care without reducing the quality. In the long run that will happen. In the short run, it will not. Successful deployment of preventive and evidenced-based measures may begin showing improvement in ten years, probably not before.
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> "For instance, preventive immunizations a year for the neediest of our patients will cost $320,000 just to buy the shots, not including any administrative fee. That's one practice with one relatively small population. That's the cost of three shots per patient the first year. That does not include the cost of mammograms, colonoscopies, bone densities, etc.

> "The best way to reduce costs in the long run is with evidenced-based medicine. Medical and Surgical specialty societies' standards of care often reflect the welfare of their constituencies. The ONLY check and balance between quality and cost is evidenced-based medicine. And, the ONLY way to successfully deal with the cost of healthcare is to intervene at the point of care when what '**can be do**' is confronted by what '**should be done**.'
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> "The President cannot reform healthcare just by controlling cost and squeezing physicians. Utilization must be controlled but without rationing. More and more utilization is driven by patient demand. The majority of excessive cost in Medicare can be eliminated by the effective and appropriate management of end-of-life issues and the elimination of the ineffective and unsuccessful care which is given in the last 90 days of life."

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.
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> 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.

"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."

Like Medical Home, Primary Care is seen as the answer

> "'We see huge regional differences in health-care quality,' says IBM's Grundy, whose department buys health insurance for 386,000 employees around the world. There's almost an inverse relationship between cost and quality, with the better quality in the states with a high concentration of primary-care providers,' he says. 'Primary-care doctors are trained to manage the 'whole person,' which can help keep seriously ill people doing well and out of the hospital.
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> "'Seeing too many specialists produces 'fragmentation,' says Donald M. Berwick, M.D., president and CEO of the Institute for Healthcare Improvement, a not-for-profit organization based in Cambridge, Mass. 'If you have 18 doctors, you'll have more coordination problems than if you have three.'"

What Have We Learned?

The last thing any of us wants is a healthcare system in which a patient is denied certain care based on age. In reality, there are some 80-year-old patients who should have a coronary by-pass and there are some 50-year-olds who should not. In addition, just because we can do something does not mean that it is appropriate to do it.

Often the most loving thing which can do for a parent, a spouse, or for other loved ones is to say "no," to tests, procedures, or invasive care. The ONLY consideration in healthcare decisions should be the welfare of the patient and often that welfare is best defined by what you choose not to do rather than by what you do.

What Should We Do?

- Encourage primary care. Fewer medical-school graduates are going into primary care because they can make much more money as specialists, no small consideration when faced with paying off six-figure student loans. Medicare is currently studying paying primary-care doctors extra for functioning as a "medical home" for patients, helping to manage their chronic ailments and coordinating care provided by specialists.
- Find out what really works. The government should fund more research comparing different treatments for common conditions, and then scale reimbursements to encourage the use of the most effective care. That would help discourage the unnecessary treatments and tests found in high-spending regions.
- Think twice about drastic measures. More aggressive hospitals more often use treatments such as feeding tubes and cardiopulmonary resuscitation in patients nearing death. But those measures might not extend life for long, if at all, and can be uncomfortable.
- Every adult should have an "advance directive" (available at www.caringinfo.org). It gives your preferences for care in the event you are ill with no prospect of recovery and unable to express your wishes.

- Consider hospice care for a patient who, in the opinion of doctors, is likely to die within six months. Studies show that patients receiving hospice care on average live slightly longer than those with the same illnesses who are not in hospice.
- Don't be pressured into agreeing to invasive life-support treatments, such as feeding tubes, without a thorough discussion of the patient's prognosis, personal preferences (if known), and overall condition.

Healthcare reform is a complicated issue with many parties having their own agenda. As healthcare providers, we must continue to advocate for our patients, but that advocacy must not be just to keep doing more, when doing less may be the compassionate, human and right thing to do.