# James L. Holly, M.D.

**The Future of Healthcare: Continue the Past or Change?**
**By James L. Holly, MD**
**Your Life Your Health**
***The Examiner***
**January 4, 2018**

With the new Federal budget proposing a trillion dollar reduction in Medicaid expenditures and a $500,000,0000,000 (that's $500 Billion) reduction in Medicare payments over ten years, every one has to be concerned with what level of healthcare will be available through these two programs. No doubt the fraud, abuse and waste in these programs is great. No doubt we have to do something to rein in the cost of healthcare, if we are ever to balance our Federal budget. And, no doubt the only way to control cost and to promote savings is to reduce the amount of unnecessary and/or inappropriate care which is being accessed through these programs. The critical question is "will less care mean poorer health?"

Early in the last Presidential administration, proposals were made to reduce healthcare costs. In one analysis a CNN reporter said, "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.

My response was, "The hope that preventive care will reduce the cost of care without reducing the quality may happen in the long run. However, in the short run, it will not. Successful deployment of preventive and evidenced-based measures may begin showing improvement in ten years, but probably not before. For instance, preventive immunizations a year for the neediest of SETMA's 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."

Nevertheless, less care may not mean less health. The best way to reduce costs in the long run is with evidenced-based medicine. If that were to become the standard, some care which is now being paid for by the government would no longer be paid for as some medical and surgical specialty societies' standards of care often reflect the welfare of their constituencies. Many types of care which is not justified by evidence would cease to be paid for by the government.

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 done' is confronted by what 'should be done.'

The reality is that policies cannot reform healthcare just by controlling cost and squeezing physicians. Utilization must be controlled but without administratively rationing of care. Since 1965, more and more utilization has been driven by patient demand. In fact, 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 180 days of life. But, that will require collaboration between patient and provider at a time in a family's life when the pressure is on "to do to every thing which can be done as a supposed act of love and care."

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.

"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.

"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."

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 study 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."

The challenge for healthcare providers and for healthcare recipients is to engage one another in rational conversations about what could and what should be done. The answer to these two questions are most often not the same.