Too much of a good thing?

That assertion — that better care costs less — is the seemingly counterintuitive research outcome of the Dartmouth Atlas Project. The 2008 study found that for chronically ill Medicare patients more health care interventions — doctors’ visits, hospital stays and the like — increased spending but did not produce better patient outcomes or satisfaction. Two-thirds of patients in the study were diagnosed with one or more of these diseases — cancer, congestive heart failure and chronic lung disease.

“The extent of variation in Medicare spending, and the evidence that more care does not result in better outcomes, should lead us to ask if some chronically ill Americans are getting more care than they or their families actually want or need,” said Risa Lavizzo-Mourey, M.D., M.B.A. Lavizzo-Mourey is president and chief executive officer of the Robert Wood Johnson Foundation, which provided principal funding for the research project done by the Institute for Health Policy and Clinical Practice at Dartmouth Medical School.

The Dartmouth Atlas Project found huge variations in dollars spent on chronically ill Medicare patients in the last two years of life, from a high of $59,379 per patient in New Jersey to a low of $32,523 per patient in North Dakota. In Tennessee, expenditures hit $42,478; the U.S. average was $46,412. The number of services patients received was driven by the number of health care providers and facilities in the area. One-third of annual Medicare dollars are expended on chronically ill patients who are in the last two years of their lives, the study says. Spending on Medicare and health care overall is predicted to skyrocket in the next decade as the baby boomers age.

“We need to benchmark the best systems and use policy to drive providers toward the benchmark by holding them accountable for the volume of services they deliver,” asserted study co-author Elliott S. Fisher, M.D., M.P.H., and director of the Center for Health Policy Research in the Dartmouth Institute. The study suggests academic medical centers and federal agencies need to lead the way by conducting research on when chronically ill people should be hospitalized, referred to specialists and recommended for other tests, treatments and services.

The health care cost-benefit conundrum

As the outsized baby boom generation moves through the health care system in the next few decades, some observers suggest that studies like the Dartmouth Atlas Project could be used to promote health care allocation in America. People develop more chronic health problems and use more health care dollars as they age; life expectancy has continued to climb in the United States to a record high of 78.1 years. By 2030, the number of Americans age 65 and older is expected to double to 71 million, which will account for 20 percent of the U.S. population.

Government policymakers already balance the cost of saving lives against the benefit gained based on economic models that weigh identified amounts of risk against people’s willingness to pay to contain it. Vanderbilt economist W. Kip Viscusi, Ph.D., has done a lot of these analyses, which rely on input from people who will be affected to quantify the trade-off between money and small risks of death. He understands that might make some people uncomfortable.

“When people hear that economists are putting a dollar value on human life, they imagine how we are conceptualizing that number,” observes Viscusi, the co-director of Vanderbilt’s new Ph.D. Program in Law and Economics and the first University Distinguished Professor.

“All the numbers I use are based on the preferences of people who actually face risk,” explains Viscusi, one of the world’s leading experts on cost-benefit analysis whose estimates of the value of risks to life
and health have been used extensively by the Environmental Protection Agency, the Federal Aviation Administration and other government regulators. “What matters is people’s preferences, what they say, their willingness to pay for risk reduction. You ask the people who are affected.”

While health care economic models often use “quality-of-life” adjustments that reduce the value of saving the lives of older people because they have more health problems and less time to live, Viscusi thinks this methodology is misguided and without theoretical basis. Research shows that neither patients with a chronic illness nor older individuals are willing to take big risks with their personal safety, an indication, Viscusi says, that they continue to place a high value on their lives regardless of physical limitations or aging.

“There’s a danger that people would get shortchanged if you do the raw calculation based on remaining life expectancy,” he says.

And Viscusi points out that health care studies that look backward two years from when patients die — as the Dartmouth Atlas Project does — don’t account for any positive results of expenditures or for how physicians would even know their patients had only 24 months to live when care decisions were being made.

“For decades economists have cited expenditures in the last two years of life as a sign of wasteful medical expenditures,” Viscusi observes. “Raising this issue has

No longer a death sentence

When Ken Lucero was diagnosed with human immunodeficiency virus (HIV) in 1988, he prepared to die. Two decades later, his story shows how treatment advances have changed what once were terminal diseases into chronic illnesses that people live with for years, often until they die from other causes.

“Back then HIV or AIDS was a death sentence,” recalls Lucero. “I had friends dropping like flies.”

In 2007, after struggling for several years with health problems and consulting with 12 specialists, Lucero’s prognosis turned grim: six months to live. He moved from Dallas back to Lawrenceburg to be near family and within three weeks was treated at Vanderbilt University Medical Center by Comprehensive Care Center Medical Director Stephen Raffanti, M.D., associate professor of Medicine.

“He said, ‘I think there’s something else going on with you,’” Lucero recalls. He had lost vision in his left eye, one clue that informed a diagnosis of infection at the base of the brain and a related partial blockage of the carotid artery. After a delicate surgery Lucero improved, but other health hurdles — including a PICC line infection — brought him to Vanderbilt again early this year.

“Nobody knew if I was going to live or die,” he says. “I couldn’t feed myself, I couldn’t dress myself, I couldn’t bathe myself.”

That’s when Raffanti asked him if he wanted to go home, and if he wanted to continue liquid nutrition. His answers were “yes” to going home, and “no” to liquid nutrition.

Back in Lawrenceburg, Tenn., Lucero continued on antibiotics and regained strength as he was cared for by his mother and two nurses — one his sister. By his April appointment at the Center, everyone was amazed at his condition.

“Treatments aimed at controlling the underlying virus became available; unexpectedly, patients’ immune systems grew stronger with this intervention. Mortality rates plummeted. Today, with proper medication, HIV/AIDS patients can expect to survive for decades.

“You could say that the human effects of the disease have changed years after diagnosis,” Raffanti says.

In 1994, the year the Comprehensive Care Center opened, Raffanti says he lost 350 patients.

“It was really just a chronically progressive illness,” he recalls, and about the best doctors could do was to get to know their patients and understand their wishes for dealthbed care.

“We got very good at diagnosing the complications of AIDS,” he says, many of which were relatively rare until then. “We got much better at treating them.”

Then, in 1996 new drug treatments aimed at controlling the underlying virus became available; unexpectedly, patients’ immune systems grew stronger with this intervention. Mortality rates plummeted. Today, with proper medication, HIV/AIDS patients can expect to survive for decades.

“The bottom line is most of our patients will not die of HIV disorders,” says Raffanti. Patients still must come to terms with a chronic illness that requires lifetime medication and limits lifestyle choices, while doctors have to refocus on treating these patients’ aging-related illnesses, some of which are caused and exacerbated by treatments, Raffanti explains.

It is imperative to help patients “chart that very dangerous course through the final stages of an illness,” preferably by collaborating and not simply through crisis intervention. Some patients will choose hospice care, to “die in control,” he says.

When he’s talking and listening to patients, Raffanti says some days he is keenly aware the waiting line is getter longer on the other side of the door.

“It’s extremely time-consuming and energy-consuming to do it right,” he says. But doing it right is what the patients want. “Some doctors are recognizing that patients have knowledge, that they are comfortable making choices,” Lucero says. “Why not allow them that?”

ELIZABETH OLDER
This is really the “big talk”

As the debate looms about who should get what share of America’s limited health care resources, Roy Elam has a proposal that would put the people most likely to be affected in the middle of the conversation: require every 65-year-old American signing up for Medicare to discuss their preferences about medical interventions and end-of-life care.

“Death is not an event. Death is a process,” Elam explains. “We should begin the discussion about death at the age of 65 for everybody and every five years have the discussion again...If we begin talking about this as a culture, we can know what people really want.”

People diagnosed with a life-threatening illness at any age could be assigned a nurse, a social worker or another trained professional — a coach, as Elam sees it — to help them deal with evolving medical issues, but also to listen to concerns and talk about sensitive topics like when to stop treatment. Other changes would be needed to support this societal discussion, he adds, like instituting a reimbursement system that rewards doctors for time spent counseling seriously ill patients and finding new ways to talk about palliative and hospice care so patients don’t hear “as far as we’re concerned, you are going to die.”

Elam has forged a personal connection with that dilemma as a longtime student of medical ethics, board chairman of Alive Hospice and a husband who was caregiver for his dying wife. But he is optimistic that medicine today is shifting more toward caring for the whole person, rather than focusing on fixing body parts. And he believes helping patients and families make peace with declining health and demise is part of that.

“We want them to know that doctors have heard the story of their illnesses and the larger story of their lives,” Elam explains. “We want them to know we genuinely care about their pain and suffering.”

Van Horn says it difficult to imagine how policymakers would be able to justify health care decisions that keep treatments that carry even a small chance of success from seriously ill patients.

“How do you take that away from them? I think that’s very difficult to do,” he observes. “I think we need to recognize there is a limited amount of resources. As resources are committed here, they’re not committed there.”

Because of this reality, Van Horn says physicians and other medical professionals need to be out in front of the discussion of what he calls a “societal, cultural resource problem.”

“Clinicians should be the people involved in making that decision, not economists,” says Van Horn, an associate professor of Management.

“Despite our insatiable demand for technology, we are not in the position to commit unlimited resources to everybody in the last years of life,” he adds. “I don’t want economists to be the guiding force in what care is provided at that point.”

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Extinguished

A comprehensive look at the end of life