# A DOCTOR'S VISION FOR MEDICARE

## WE CAN IMPROVE QUALITY OF CARE BY RESTORING BALANCE TO SYSTEM

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Everybody knows what the federal budget's long-term problem is. The president knows. The Republicans in Congress know. The Democrats in Congress know. The policy community knows. You know. It's Medicare. I am a physician who has been studying Medicare data throughout my professional life. But now that I'm closing in on becoming a beneficiary, I am thinking more about what I'd like my Medicare program to look like.

My Medicare would be guided by three basic principles:

• It should not bankrupt our children. Let's be clear: Medicare is rightly the central source of concern in the deficit debate. Its expenditures are totally out of control, and represent a huge income transfer to the elderly from their children. It's a pro-gram crying out for a budget.

So let's pick a number—more specifically, a proportion of total economic output— to cap Medicare. Now the number is 3 percent to 4 percent of GDP. We can live with that. Distribute it to geographic regions based simply on how many beneficiaries live there. Expect howls of protest: Urban areas will complain their labor costs are higher; rural areas will complain they cannot achieve the same economies of scale. And everybody will argue that their patients are sicker.

Ignore them all: Make it a block-grant program. Sure, this raises other issues, but you get the principle.

For those who view this as a tea party solution, consider this: I drive a 1999 Volvo and live in Vermont—that should tell you something.

• It should not waste money on low-yield medicine. I don't change my Volvo's oil every 1,500 miles, even though some mechanics might argue that it would be better for its engine. Nor do I buy new tires every 10,000 miles, even though doing so would arguably make my car safer. But in Medicare (as well as the rest of U. S. medical care) such low-yield interventions are routine.

Measurements considered normal in the past now trigger treatment for high blood pressure, high cholesterol, diabetes and osteoporosis. Tiny abnormalities that were invisible in the past now trigger follow- up scans, fiber-optic examinations, biopsies and surgery.

Increasingly, all Medicare beneficiaries are being viewed as being "at-risk" for something, particularly heart disease and cancer. We doctors joke that the well person is the one we have not examined thoroughly enough. (The last Medicare skin exam that failed to identify something that might lead to skin cancer occurred in 1970.)

But it's not funny anymore. Because once you are labeled at-risk, something must be done.

My Medicare would recognize the problems with this approach. Because almost everyone is transformed into a patient needing intervention, it's an approach that costs a huge amount of money. And no matter what we doctors do, we can't take you to zero risk.

But we can cause harm. Our medications have side effects; our surgeries and procedures have complications. And occasionally our interventions cause death.

My Medicare would focus on patients who are genuinely sick: those who have symptoms (e. g., chest pain) or are at high risk of something bad happening (e. g., really high blood pressure). These are the patients for whom the benefits of medical intervention clearly outweigh the harms. The rest of us are better off left alone.

That's right, most of us would do just as well — or better — with less medical care. Restoring balance to the system will first require more balanced information for patients because what they get now systematically exaggerates the benefits and downplays (or ignores) the harms of intervention.

But it will also require that someone take responsibility for deciding which treatments should be provided based on the evidence of which treatments lead to better outcomes. If you don't want the government to do this, then your doctor will need to step up to the plate. And the only way that will happen is to balance his financial incentives.

Those who believe they have a fundamental right to receive low-yield, ineffective and harmful care are sure to invoke the "R-word"— rationing. But let's hope they at least have the good sense not to say it while at the same time arguing for less government spending because they don't want to bankrupt their children.

• It should recognize the value of having time to talk with your doctor. The current system rewards physicians for doing things to patients, not for talking with them. Not surprisingly, we do too much. Too many clinic visits lead to another medication being started, another test being ordered and a referral to another physician. The end result is totally predictable: too many medicines, too much testing and too many cooks in the kitchen. But there is another problem: Subsequent clinic visits are increasingly devoted to going over medicines, reviewing test results and figuring out what the other physicians had to say. No wonder patients are increasingly dissatisfied with the process.

My Medicare would reward doctors for taking time to have a conversation. It would recognize the value of acknowledging suffering, providing reassurance, discussing options and learning how different patients want to approach care.

What would I want to talk about with my doctor? Maybe it's a topic, however mundane, that means something to me, like whether the Jets will knock off the Patriots again this year. This serves a purpose: I want to know (and like) my doctor.

I want to talk about important things too, things that are bothering me right now. I want my doctor to care, provide insight as to what is going on, and to consider carefully whether or not medicine can help. I don't want a knee-jerk response to some perceived need to "do something" on my behalf. I value the physician who can candidly discuss what medicine can and cannot to. By the way, that takes time. It requires a system that rewards doctors as much for thinking about (and talking with) patients as doing things to them.

I want to talk about aging gracefully. My Medicare would be really good at this. It would help patients understand the trade-offs between the length of life and the quality of life. It would help patients understand why the side effects of early detection — overdiagnosis and overtreatment — are even more pronounced as they age (simply because there is less time for abnormalities to become important problems). And it would help patients understand the futility and the suffering caused by aggressive interventions at the end of life.

If you were hoping to play the "death panel" card, now's your chance. But don't play it and then pretend you care about the budget.H. Gilbert Welch, M. D., is a professor of medicine at the Dartmouth Institute for Health Policy and Clinical Practice and the lead author of "Overdiagnosed: Making People Sick in the Pursuit of Health."