

The 'kill granny' bill

By BETSY MCCAUGHEY

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AS the health-reform bills move through Congress, the prognosis for Medicare patients gets worse and worse.

The Senate Finance Committee bill (generally called the Baucus bill, after Chairman Max Baucus) robs the elderly to cover the uninsured -- like snatching purses from little old ladies. The House bills already cut future funding for Medicare by \$500 billion over the next decade. The Baucus bill would slash a similar amount, just when 30 percent more people enter the program as baby boomers turn 65.

The Baucus bill also puts new limits on what doctors can do for patients in Medicare:

* A "race to the bottom" provision (p. 102 of the revised chairman's mark) would take effect each year for the next five years. The provision penalizes doctors who end up in the 90th percentile or above on the cost of what they use to treat their patients, compared with national averages. The intent is to force down the cost of care, year by year. Yet this blunt instrument can't determine which care is actually *wasteful* -- it will punish doctors for treating high cost patients with complex conditions. Inevitably, it will lower the *quality* of care.

* Even more devastating is the amendment Sen. Maria Cantwell (D-Wash.) got inserted into the bill (revised chairman's mark, pp. 102-3). It gives the Secretary of Health and Human Services the power to define quality, cost-effective care for each medical condition and penalize doctors who spend more on their patients.

The law establishing Medicare in 1965 barred the federal government from interfering in doctors' treatment decisions. Slowly, Medicare regulations have begun unraveling that protection. Now the Cantwell amendment finishes the job.

This is the most extreme change to Medicare ever. Dr. David McKalip, a Florida neurosurgeon and a board member of the Florida Medical Association, predicts: "The only doctors left in Medicare will be those willing to ration care and practice cookbook medicine."

It's reasonable for Medicare administrators to strive to get value for dollars spent. In recent years, Medicare has taken a slow, tight-fisted (and sometimes arbitrary) approach to paying for new drugs or medical devices. But Cantwell aims directly at doctors' decisions.

That's not surprising. President Obama and his advisers vilify doctors for over-treating patients. Dr. Ezekiel Emanuel, brother of White House Chief of Staff Rahm Emanuel and a key Obama health-care adviser, argues that the Hippocratic Oath is largely to blame for the "overuse" of medical care.

In his view, doctors focus too much on the needs of their own patients; they should be taught to ask whether the money they're spending on a patient is worth it. To curb doctors' spending, the stimulus legislation launched a process of sending doctors protocols via computer on what the government deems "appropriate" and "cost-effective" care. Doctors who are not "meaningful users" will be punished financially.

When I warned that this meant the government would be interfering in doctors' treatment decisions, CNN and FactCheck.org said that was untrue. But Dr. David Blumenthal, appointed in March to head the new system of computer-guided medicine, settled that debate. In the *New England Journal of Medicine* (April 9), he confirmed that "embedded clinical-decision support" (his term for computers telling doctors what to do) would be used to reduce costs, and he predicted that some doctors might rebel against tight controls.

The Baucus bill completes the framework for tying doctors' hands when treating the elderly.

Driving all this is the misconception that doctors spend wastefully on patients who are about to die. Newsweek's recent cover story, "The Case for Killing Granny," argues that "the need to spend less money on the elderly at the end of life is the elephant in the room in the health-reform debate."

Numerous studies prove that is false. In 2006, Emory University researchers examining the records of patients in the year before they died found that doctors spend far less on patients who are expected to die than on patients expected to survive.

The Emory researchers said it's untrue that "lifesaving measures for patients visibly near death account for a disproportionate share of spending." They also found that doctors often can't predict when a patient is in the last year of life.

In any case, the health-reformers' plan to cut spending on patients 65 and older won't simply reduce end-of-life care, it will also eliminate care for patients who are perfectly capable of surviving their illness and going on with life.

Betsy McCaughey is chairman of the Committee to Reduce Infection Deaths and a former New York lieutenant-governor.