

Medicine and Money

Financing of care for fatal chronic disease: opportunities for Medicare reform

Joanne Lynn, *Director*, Anne Wilkinson, RAND Center to Improve Care of the Dying, 1200 South Hayes St, Arlington, VA 22202-5050

Lynn Etheredge, The George Washington University Health Insurance Reform Project, Washington, DC

For the American College of Physicians-American Society of Internal Medicine End-of-Life Consensus Panel (see Acknowledgment)

Correspondence to: Dr Lynn, jlynn@medicaring.org

Competing interests: None declared

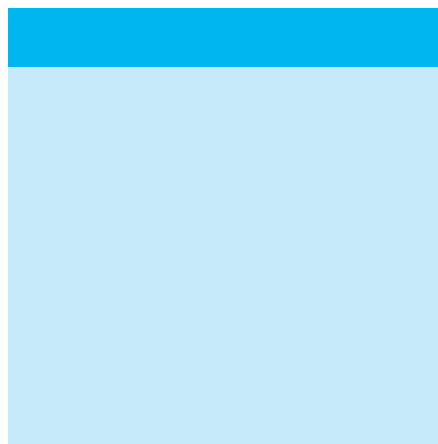
Funding: The Greenwall Foundation provided support for the development of the original paper

West J Med 2001;175:299-302

CASE REPORTS OF CONTRASTING CARE PATHWAYS

Ordinary course of care

Mary Smith, 78 years old, had osteoporosis, diabetes mellitus, mild heart failure, cataracts, and breast cancer. Her husband, 84 years old, had cognitive impairment and, since having a stroke, was dependent for transfers, bathing, and dressing. They lived on a small pension in a rented apartment. Their children lived at a distance, and the Smiths had few contacts except for health care. During the turmoil and financial challenges of Mrs Smith's cancer treatments, Mr Smith worsened and entered a nursing home. Mrs Smith wore herself out with worry, and her heart failure worsened. Mr Smith died in a hospital intensive care unit of a urinary tract infection. She

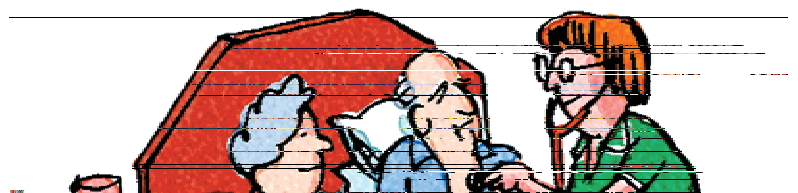


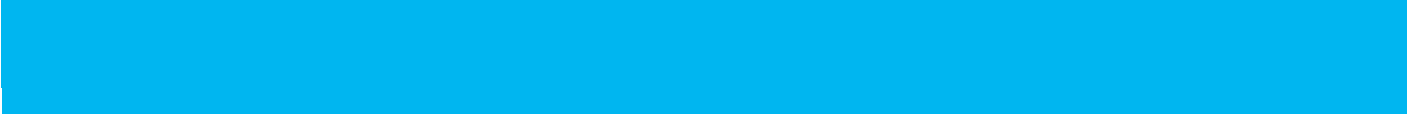
developed back pain and constipation but would not go to her physician's office for an evaluation. Eventually she became delirious

and was admitted to the hospital as an emergency. She could not keep her apartment and entered a nursing home. A few months later, Mrs Smith also died in the hospital, after being transferred because of pulmonary edema. Through all this, the Smiths had a dozen different physicians, several hospitalizations (including dying in the hospital), and much suffering.

Better course of care

Mrs Smith's physician recognized that the Smiths' situation was rife with risks. As soon as she was diagnosed with cancer, Mrs Smith's physician involved a nurse care coordinator who worked with the Smiths through the rest of their lives, planning ahead and marshalling needed services in a timely way.





The care coordinator contacted the Smiths' old church and elicited some friendly visitors and volunteer help. The city provided in-home aides and repair services to enable them to stay at home, even when chemotherapy left Mrs Smith fatigued. When Mr Smith had another stroke, a home care program helped for a few weeks until he died at home. Mrs Smith had more trouble with shopping and housework.

THE CASE FOR REFORM

The reimbursement system probably did not cause the Smiths' "ordinary" care to be com-



