

英文影印版

实用血管外科学

Practical Vascular Surgery

James S. T. Yao
William H. Pearce



科学出版社



McGraw-Hill

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Preface

In recent years vascular surgeons have been caught up in the enthusiasm over new technology. This new technology has provided minimally invasive approaches for treating a wide variety of vascular diseases. Unfortunately, this new technology is untried, and long-term results are scant. Although it is important to stay abreast of new developments, it is also important to review traditional techniques for treating vascular disease. These techniques have provided us with sound, durable treatments. The purpose of this book is to focus on the practical aspects of vascular surgery encompassing office practice, critical care, critical pathways, simplified operative approaches, and standard surgical procedures. In the current economic environment, it is important that our treatments be efficient, cost-effective, and durable. By critically reducing excesses in diagnostic modalities and limiting long-term follow-up protocols, standard vascular surgical procedures will compete satisfactorily with the newer endovascular techniques that may be more appealing on the surface, but may be less durable.

James S.T. Yao, MD, PhD
William H. Pearce, MD

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I



Practice of Vascular Surgery in a Changing Environment

Medicare, Present and Future

Forces for Change

Hugh H. Trout III, MD, FACS

INTRODUCTION

Shortly after assuming office, President Clinton risked, and indeed spent, considerable and precious political capital on trying to change (euphemistically called “reform”) the health care system in the United States. Political scientists and historians will no doubt debate why a young and untested president should take such a risk so early in his first term. Interestingly, perhaps an even more profound question is why he ventured into this health care morass at all. The answer is no doubt complex and filled with Byzantine intrigue but, at its core, it probably reflects that the president foresaw an impending national crisis and made a courageous, if flawed, attempt to address the fundamental problems so as to reduce the long-term adverse impact of enhanced technology and an aging population on our health care system. Although the “reform” effort failed, the future crisis that the president presciently perceived remains.

Medicare payment policies have, to a significant extent, become the *de facto* payment policy standard for most insurance companies—that is, the insurance companies base their payment schedules on some percentage of the Medicare payment. Accordingly, Medicare policies are of critical concern for most physicians. Moreover, the Medicare system has come under intense pressure to constrain costs and the changes now taking place are almost all related to these financial limitations. Trying to predict what changes in Medicare will take place in the early part of the 21st century is futile, but it is possible to describe the forces that mandate change. Although understanding these forces may not make physicians any happier, it may be helpful in reducing the belief that an ill-defined “they” are capriciously or duplicitously trying to wreck a perfectly good and efficient health care system. Accordingly, this chapter discusses the pressures requiring change and describes some of the changes that will occur in the beginning of the 21st century.

Some of the fundamental problems are a limited amount of money available for health care; an aging population; expanded technology, an oversupply of physicians (primary care physicians as well as specialists); a medico/legal system that is inefficient

in addressing inappropriate medical practice; an appalling willingness of politicians and the public to accept conventional wisdom ("politically correct") rather than policy based on experimental evidence; lack of a system that provides appropriate incentives for the delivery of health care; and an ethos that does not include an understanding of how efficiently and at what cost the medical profession can prolong the process of dying. These problems are not unique to this country; indeed, they afflict all industrialized nations. Moreover, they cannot be "solved" (the only "solution" for most health care problems is death), but can only be managed.

Some of what follows is based on the author's opinion gleaned from living in Washington, DC, the home of policy mavens, as well as serving as the Chair of the Society for Vascular Surgery/International Society for Cardiovascular Surgery (SVS/ISCVS) Government Relations Committee. Each topic could serve as the basis for a book or a doctorate degree and much has been written about each. Accordingly, I have not attempted to use references for my statements as access to federal documents is not readily available to the medical profession, and much of what I have included comes from secondary sources, equally difficult to access. If any reader wishes to have additional information about a particular topic and has difficulty gathering it, they should contact me and I will try to help.

FORCES FOR CHANGE

Limited Money for Health Care

The percentage of the gross domestic product (GDP) that is devoted to health care has increased steadily (although, of late, at a slower rate of increase). In 1996, it was 14%, and is anticipated to grow to 16% by the year 2000 and 18% by 2005. The per capita health care expenditure is anticipated to increase from \$3759 in 1996 to \$5198 in 2000, and to \$7352 in 2005. Predicting health care costs, however, is notoriously unreliable. For instance, in 1965, when Medicare and Medicaid were implemented, it was anticipated that in 1990 total expenditures for Medicare would be \$9 billion, and for Medicaid would be \$1 billion. Actual 1990 expenditures were \$106 billion and \$76 billion, respectively.

This trend of constantly increasing health care expenditures, whether on a per capita basis or as a percentage of GDP, clearly cannot continue. As a consequence of the stabilization of total health care expenditures (as a percentage of GDP), as they almost certainly must by the year 2010, per capita expenditures will obligatorily decrease as the population of persons older than 65 begins to increase rapidly (per capita expenditure equals total health care costs divided by number of patients). Thus, despite more patients and more sophisticated technology, it is almost certain that fewer dollars will be available after the year 2010 for per capita health care.

Aging Population

World War II resulted in a low birth rate throughout the industrialized world during the conflict. In the succeeding prosperous years, starting in 1945, the birth rate in the United States accelerated dramatically with what is now known as the Baby Boom. The members of this cohort will begin to reach 65 in the year 2010 with unsettling consequences. It is instructive to reflect on the circumstances surrounding the beginning of Social Security in the United States in 1935. Life expectancy was 62 years and it was expected that 7% of adult life would be spent in retirement. In 1995 those figures