Let's turn health care over to the IRS

Our government wants us healthier and, by doing so, hopes to contain health care expenditures. It postulates the major reason we are not healthier and overspend is that our doctors have been motivated to keep us sick to maximize their incomes by providing the highest possible volume of "fee for service" *sickness* services. Thus, they assert the outcome "value" of services is directed at maintaining sickness, not health or wellness. Allegedly, that is all to change.

On April 4, 2016 CNBC reported the Center for Medicare and Medicaid Services (CMS) has a way to measure the previous elusive *wellness* "outcome value" of services a physician provides each patient. It will pay each physician "up front" to manage each patient to assure all will be provided the "value" services each needs to achieve maximal outcome wellness.

Valid and reliable measures of outcome wellness to assess the value of physician services are difficult to define. This is due to the unique genetic, biological, behavioral characteristics of each patient, the role of socioeconomic determinants of health and the often limited, equivocal or controversial scientific evidence of the wellness benefits of certain services. For instance, the recent longevity decline for certain groups of white males and females is highly unlikely due to the health services provided by their physicians. Even with the advent of "big data", I doubt these issue have been solved or – if they have – whether the proposed physician management approach is the best strategy.

True wellness value measures would track how successful a physician was in preventing such outcomes as "deaths", "hospitalizations", "re-hospitalizations", "cancer occurrences and re-occurrences", "strokes", "heart attacks", "diabetes", "obesity", "serious injuries", "intestinal bleeds", and "pneumonias" to mention a few. To date, we largely have been unable to determine in a specific patient if a specific wellness service would prevent a serious negative outcome and whether the patient would even avail herself or himself of the service. Thus, we have relied on the "generalizability" of certain population statistics - and picked widely agreed upon "process" measures of wellness services thought valuable for the overall patient population or certain subsets. These are crude measures and have serious limitations when assessing physician "wellness" performance. Below are some examples.

I am in my seventies. Each year my physician tells me and others my age to get a flu shot and assure our "pneumonia shot" is up to date. I did not get a flu shots this year. Immunological protection in older people –especially last year – had not been great, perhaps in the 30% range. I got nailed with influenza this year and spent 3 miserable weeks. I'll get a flu shot next year even though the numbers probably will not change. Suddenly, 30% looks pretty good even if I have no idea if a flu shot will protect me. I know of many people who have been referred for a "pneumonia shot" or "shingles shot" who would comply but cannot afford the uncovered cost of the vaccine. How will my physician be held responsible for adverse outcomes in such cases?

Will my doctor urge me to limit my dairy and animal oil intake in favor of certain vegetable products? Several recent studies have shown such wellness actions can actually increase cardiac risk and death in some. There are no guidelines regarding people my age taking an aspirin each day to reduce heart disease. Even in sixty year olds, the guidelines are equivocal as regards balancing cardiac and bleeding risks. Based on my past history - but no good science - I believe I have a greater risk of a vessel occlusion than GI or brain bleed. Will my doctor get penalized if I am wrong?

For years physicians have been financially penalized for hospital readmissions since there is strong evidence their volume can be reduced. The problem – like above – is in "which cases" - and what specifically should the physician do – to obviate the readmission. April JAMA Internal Medicine published a study by Andrew Aeurbach, MD, MPH that revealed 27% of readmissions are preventable, with about 52% of culpability occurring at initial admission with several system components and personnel involved. It will be interesting how CMS will allot readmission culpability to one's personal physician. The good news is that using this methodology physicians should now be "off the hook" for 3 of every 4 readmissions.

I doubt CMS has perfected wellness value measures that can be meaningfully, validly, reliably and fairly applied to reimburse physicians. But even assuming they have, is this the most effective way to apply them?

I believe it would make much more sense for CMS to provide each patient his or her's wellness profile and specify the services required to stay well. A confidential copy would be provided the patient's physician, insurance carrier and the IRS. Like with the health insurance mandate, an individual could be provided tax credits, subsidies and/ or penalties to encourage receiving the specified "effective" wellness services. Insurance companies would be required to cover these services and physicians would be assured fair payment for providing them. Such an approach motivates patients, insurance companies and physicians to promote effective wellness services through "direct" incentives to each player, eliminating the costly, indirect reimbursement mechanism proposed that targets only one player.

If our government is going to take over health care lets be smart and go all the way. What possibly could go wrong?

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