

## Health Reform – Where is the beef?

Americans are hopelessly confused. They have little idea whether proposed health reform legislation will produce significant gains or profound disaster. Few defend the status quo and nearly every citizen supports the goals of universal access, better preventive health practices, higher quality care, reduced cost escalation, and elevated health status.

No *responsible* citizen can be for or against “it” because, paraphrasing former President Bill Clinton, “it depends upon what the definition of it, is”. No one has articulated simply and convincingly how – and how well – each proposal will accomplish these shared goals - and the associated unintended consequences and costs. We deserve a “scorecard” developed by an independent, non-political group to assess each proposal’s gains, costs, and tradeoffs, not more media spin and rhetoric.

Such a group would delineate specific summary *quantitative* measures for each goal. They would then present optional achievement levels, the economic and social cost and consequences of reaching each level, how we would alter the health system to attain each level, and, most importantly, the *assumptions* underlying conclusions and projections. Such assumptions are the “beef” that is missing from the current debate. Below are a few examples.

How many doctors are yanking out children’s tonsils for sore throats or performing other unnecessary and ineffective diagnostic and therapeutic procedures? How much will be saved by reducing these numbers and how will it be done? What will be the bureaucratic cost to do it and the affect, e.g., delays, denials, upon those patients for who care is justified? Note: Most patients visit primary care physicians who perform few procedures whereby they can drive up the “volume” to benefit financially.

What will central government do differently to eliminate such care, as well as waste, fraud, and futile care? What will be the associated bureaucratic costs, cost savings,

and social costs? Note: Despite numerous initiatives in the past several decades to reduce such practices within Medicare, Medicaid, and the End Stage Renal Disease Program, government largely has been unable to establish “limits” or significantly reduce fraud, waste, or futile care - partially because of the political reluctance to say “no” to any advocacy group or voter.

What will be the minimum health insurance benefit package government will guarantee every citizen? Currently, what care do uninsured and underinsured individuals receive – and not receive - solely associated with such a financial access guarantee? What is the cost of assuring its provisions? What will such individuals have to pay for such coverage and what will taxpayers as a whole have to assume? Note: Overall, we still know little about “timely” care avoided or denied solely because of financial insurance considerations. We do know that a large percentage of individuals with excellent insurance coverage fail to avail themselves of “timely” care, especially preventive services, and comply with recommended treatment.

How – and how much - will adoption of effective preventive practices increase, how much will be saved, and what will be the bureaucratic and associated costs? Note: Except for a few procedures and practices, few health experts contend preventive measures will result in significant long-term cost savings. They add longevity and tremendous “value” to the quality of life and well-being. However, increased longevity can increase “life-long” health care costs. Moreover, few believe additional insurance coverage alone will significantly increase adoption of preventive practices but that this will require special programs and community initiatives.

How much will expanding comparative effectiveness research improve quality, decrease ineffective care, and save money? How much will such research and its application cost economically and socially, e.g., denied or delayed care? Note: Comparative – effectiveness research is crude and in its infancy; its application is limited to a relatively few “quantitative” measures of quality. Until advances in genetics and environmental

sciences truly usher in the era of “personalized medicine” – to allow the assessment of the merits of any treatment for each unique individual - we must rely upon population probabilities that often are not operational in certain individuals.

How many more individuals will have care “rationed” under various proposals and how?

Note: Two main factors produce rationing – the availability of health care practitioners and institutions and the ability to access (for financial and other reasons) desired services. The poor must rely on the government or charity for access; admittedly, they will continue to ration care to control costs. The very rich will not have care rationed since they have the financial and other means of access, whether in this country or elsewhere. The plight of the insured middle class is uncertain.

Through direct resources and employers, currently most of the middle class has broad access to care. They also subsidize, through taxes and insurance plan “cost-shifting”, uncompensated care and under-compensated “government plan” care. If the government reimburses fairly at the same rate as insurance companies – and the middle class not subjected to increased tax liability – they should not suffer increased rationing. However, if government plans continue to under-compensate practitioners and institutions, “cost shifting” will increase. This will deplete the limited resources of the insured middle class and increase the likelihood private businesses will drop insurance coverage because of increased costs, effectively driving more folks into government plans that include rationing. It, also, will make entering health care practice less attractive, likely leading to a shortage of resources and increased rationing.

Assumptions regarding the projected costs, savings, quality improvements and consequences related to organizational integration, adoption of automation and many other factors likewise require transparency and analysis.

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