Referring to the Supreme Court Rules

[Printed as “Fixing health care, no matter how the Court rules,” Akron Beacon Journal, 6/27/12]

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June, 2012

One of the best things the health care reform law has had going for it is its title: “Patient Responsibility and Affordable Care Act.” It sets out timely priorities for American health care: increase accountability and contain costs. Its greatest flaw is that it does too little of either – not enough in the way of patient accountability, while actually increasing complexity and cost.

The aftermath of the Supreme Court decision, however the ruling goes, will re-open the possibility of addressing these most significant health care policy problems. Here are three goals, and three tangible, potentially significant steps toward accomplishing them.

First, simplify. The complexity of America’s health care economy is the product of generations of adaptations to these unique characteristics of the health care market:

- Suppliers (doctors) rather than consumers (patients) generally make consumption decisions (what drugs, treatments or surgeries are to be provided).
- Third parties (government or private insurers) process most payment for services, the costs of which are ultimately covered by employers; federal, state, and local governments; and individuals or families.
- Prices are generally unknown to both suppliers (doctors) and consumers (patients) – and they generally don’t apply anyway because insurers negotiate discounts that vary considerably from one payer to the next. Oddly, only those paying cash – the uninsured – are expected to pay full charges.

Patients should expect greater control of their health care decisions, but also need to have a stake in the consequences of those decisions. Expanding access to health savings accounts and high deductible health plans – subsidizing on a sliding scale out-of-pocket expenses for those with lower incomes – offers a way to get the question of price into the basic transaction between patients and providers. In short: let’s move financial decisions to individuals and families interacting with their doctors, and deconstruct the enormous and wasteful public and private insurance bureaucracies.

Second, prevent. Over the past hundred years, medical science has yielded enormous improvements in the quality and duration of people’s lives by improving treatment of acute conditions. That very success has brought with it new challenges, including, most significantly, chronic health problems that nearly half of the population would not have lived long enough to experience a century ago. Treatment of chronic illness is now driving the explosion in health care
costs. Yet, many of these conditions are preventable through better diet, lifestyle choices, and removal of environmental threats.

With more people living longer, prevention of chronic disease must assume a larger role. Redirecting a small portion of current acute health care spending to public health, applied to research and consumer/patient education, could significantly reduce the incidence of chronic illness. Treatment is good – prevention is better, and in the end, much less expensive.

Third, think long term. For decades, a major cause of unnecessarily high and spiraling health care costs has been the steadily growing oversupply of specialists, and undersupply, and significantly lower incomes, of primary care doctors and advanced practice nurses. Bearing in mind that doctors, not patients, prescribe the course of health care, it is not difficult to understand the consequences.

Unfortunately, it has been the policy of the federal government to heavily subsidize this imbalance. Congress and a succession of administrations have sustained the inefficient and costly over-supply of specialists through major subsidies embedded in the arcana of Medicare and Medicaid policies. These payments, which exceed $12 billion per year, have historically been made exclusively for inpatient hospital (nearly always subspecialist) services. These subsidies are in addition to routine payments for these services, and are paid by no other third parties. Virtually none of these Graduate Medical Education (GME) subsidies flow through primary care settings.

This system needs to be scrapped and replaced with one setting targets for increasing the supply of primary care doctors, nurse practitioners and other primary care professionals, while adjusting downward the number of medical specialists. How? First, repeal the current Indirect Graduate Medical Education (IME) subsidies in Medicare and state Medicaid plans. Second, redirect these dollars to primary care residency training for both doctors and nurses in outpatient settings, and provide educational loan repayment subsidies for primary care doctors and nurse practitioners. Third, curtail Direct Graduate Medical Education (DME) subsidies for medical and surgical specialties beyond those needed to sustain national health manpower targets.

These are reforms that should appeal to people across the political spectrum. Containing health costs is necessary for the competitiveness of American goods and services in international markets, and critical to the future viability of publicly subsidized benefits to the more than 100 million Americans receiving Medicare, Medicaid and State Child Health insurance. Expanded consumer control – and responsibility – is appealing to consumer advocates and libertarians alike. Similarly, prevention aims at influencing, not controlling, individual choices. And thinking long term is the only way to create a health care system that is sustainable.

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