The ailing health care system: SOAP note for physician leadership

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Health care reform. The oft-used phrase has launched endless political debates and stimulated volumes of literature. Yet physicians, immersed and busy in the daily provision of care for their patients, often remain on the periphery of the health care reform dialogue. Now, timing and recent research in Wisconsin and elsewhere demand that physicians take time to visit with the current ailing patient—our health care delivery system.

Subjective—Objective

Here's what we know: as much as 40% of system costs are attributable to poor quality—overuse, underuse, misuse, duplication, inefficiency, or poor communication.[1] Preventable medical errors result in as many as 98,000 US hospital deaths each year.[2] In Wisconsin, about half a million residents still lack health insurance coverage,[3] and costs continue to substantially outpace overall economic growth and the growth in real wages. The state and nation face a shortage[4] and a maldistribution[5-6] of primary care physicians, and this imbalance continues to grow as medical students increasingly choose other specialties over primary care.[8]

Only about half of US adults receive recommended preventive and chronic care.[9] Medical practice shows unwarranted variation in cost, supply, and volume, while higher spending does not produce better quality, access, survival rates, or health outcomes.[10-11] Meanwhile, half of the US population spends little or nothing on health care, while 5% of the population spends almost half of the total amount, and 20% of users account for 80% of costs, generally for serious chronic and acute conditions.[12-13]

Cost, access, and quality are inter-dependent; 3 legs of the stool that requires balance. Lack of insurance coverage results in uncompensated care, delayed care, and inappropriate entry points, all of which contribute to higher costs and higher prices. System fragmentation underlies the poor overall performance in quality and cost: patients navigate across multiple providers and care settings, with poor communication and lack of clear accountability. Payment systems reward high-cost, intensive medical intervention over often-higher-value primary care, including preventive services and the management of chronic illness. Providers grapple further with inadequate payment from Medicare and Medicaid, along with costs for underinsured and uninsured patients, shifting these costs onto commercial insurance.

Assessment

Health care experts and opinion leaders,[14] along with a range of national expert, industry, and advocacy panels, have endorsed several goals:

- Universal Insurance—This may be achieved in various ways through employer-based, other market, and government mechanisms.
- Payment Reform—Reform by bundling of services, episodes of care, and pay-for-performance incentives.
- Measurement and Reporting—Reporting based on benchmarks, standard for price, and quality.
- Patient Centered Medical Homes—Homes to provide round-the-clock, accessible, and coordinated care; preventive, primary, and specialty care with focused disease management.

The US Department of Health and Human Services (DHHS) is currently promoting reforms based on its Four Cornerstones[15] for health care improvement:

- Interoperable Health Information Technology
- Measure and Publish Quality Information
- Measure and Publish Price Information
- Promote Quality and Efficiency of Care with Payment Incentives

Significant change will require legislative and regulatory action to support broad-based payment

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reform, achieve coverage and access goals, and promote standards for data collection and reporting across providers and systems. The public and private sectors, while awaiting such legislative action, are moving forward with health system transformation through local initiatives.

The Wisconsin Department of Health Services (DHS), through its Medicaid program, and the Department of Employee Trust Funds, through the state employee health plan, are testing a range of quality and cost-containment innovations intended for application in the wider market. These include advancement of electronic health records, collection and public reporting of quality and cost data, pay-for-performance, and provider/plan tiering mechanisms.

Several Wisconsin groups are advancing the agenda of quality and value-purchasing. These include the nationally recognized[16] Wisconsin Collaborative on Healthcare Quality, the emerging Wisconsin Health Information Organization, and the Wisconsin Hospital Association's Checkpoint and PricePoint initiatives. These efforts, together with the Wisconsin Medical Society and MetaStar, have been designated by DHHS Secretary Mike Leavitt as the nation's second Chartered Value Exchange.[17]

Governor Doyle's broader health care reform strategy relies on coverage expansions through BadgerCare, with potential purchasing reforms through his BadgerChoice proposal. BadgerChoice is a virtual purchasing pool designed to make insurance more affordable for the nearly 800,000 Wisconsin residents insured through small businesses. It is intended to allow employees to choose from several private plans, priced within a new community rating system, giving employees the opportunity to apply their employer's contribution toward the coverage they select.

As well, the BadgerCare Plus program, through expanding coverage to childless adults, will have latitude not otherwise available in Medicaid and State Children's Health Insurance Program (SCHIP) entitlement programs, to begin experimenting with value-based insurance design (VBID). VBID tailors the benefit package and copays to the evidence base of specific services for targeted groups, targeted interventions, or individual patients, measuring value by clinical and economic benefit. Such an enterprise will rely on the data from mandatory health needs assessment and health risk appraisals, as well as regularly submitted claims and utilization data.

Plan—What's the Right Course of Treatment?

Despite these significant efforts, a broad range of perspectives remain on how to shape reform, and a lack of consensus remains on how to achieve the overall goals. This is particularly true with regard to mechanisms for reducing the numbers of uninsured and for controlling costs and prices.

Numerous studies report opinions on health care reform among the public[18-19] and across health care-related professional sectors.[20] The Commonwealth Fund recently reported the results of a national survey, finding that 82% of Americans think US health care should be fundamentally changed or completely rebuilt.[21]

Yet opinions vary about the role of government. A majority (56%) of registered voters say the main goal of efforts to reform the health care system should be to make sure everyone is covered by health insurance, compared with 41% who say the main goal should be to make insurance more available and affordable in the private marketplace, even if some people remain uninsured.

Even where the goals may be shared, opinions vary about the specifics. The Kaiser poll reports that nearly 6 in 10 (59%) voters say that the costs of sick and healthy people alike should be shared over an entire group within an insurance pool, while about one-third (32%) say that healthier people should not be asked to pay more to subsidize sicker people.[22]

A 2005 survey of US health care experts—representing academia, health care industry, business, insurance, government, labor, and consumer advocacy—found that a majority support policies to build on Medicaid to achieve coverage goals.[20] At the same time, only slightly more than half felt that Medicaid and SCHIP had been successful in meeting their overall goals. And only 39% of business-sector respondents reported believing these programs have been successful.

The Towers Perrin 2008 Employer Survey reports similar perspective from among the 500 corporate leaders responding; 71% favor retaining the employment-based system for pre-Medicare coverage, while 84% oppose an exclusively government-based health care system.[23] These survey responses also demonstrate a lack of consensus around the impact of the current health system on the competitiveness of US businesses, with many respondents valuing the current system of voluntary employment-based health coverage.

The literature also reports disparate opinions among physicians.[24-31] Physicians report increasing disgruntlement with the health

care system.[32] Since 2001, surveys have found more than 70% of physicians believe that fundamental changes are needed in the US health care system.[24]

The Wisconsin Medical Society recently fielded a survey of Wisconsin physicians to measure their attitudes and opinions across a range of major health care reform elements. The clear message is ambiguity: Wisconsin physicians have a wide range of preferences, with few points of consensus on direction for reform in health care financing and delivery (A. Getzen; K. Knox; R. Rieselbach, MD, MACP; A. Bergum, MPA; D. Friedsam, MPH; unpublished data, 2008).

How, then, can Wisconsin physicians best care for the ailing patient? Today's best practice for patient care has a new essential element: physician leadership to assure that health care reform best serves our patients. Such leadership will require a more unified physician voice in advocating for appropriate health care reform. It's time to gather with physician colleagues, review the facts of the case, agree on the solutions we need to attain, and forge a consensus on the treatment plan to get there.

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