Steven C. Bergin, MD

The time is critical

Steven C. Bergin, MD, President, Wisconsin Medical Society

"By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists, and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people."

—President Harry S. Truman, in a 1945 speech to Congress

Our patient is arousable but becoming increasingly more incoherent. Cries of despair punctuate the surrounding silence. The periodic facial contortions associated with guttural moans and groans express chronic internal pain. The eyes reveal fear, anxiety, and anguish. The skin is cold and clammy, and the body is limp and flaccid. The blood pressure is slowly dropping, and the pulse is thready and weak. The breathing is shallow and labored.

Yes, our patient's chronic illness for over half a century has taken a turn for the worse. The lack of coordinated care has led to multi-system failure. Incremental managements to date have failed to produce a quality outcome. No immediate prospect for a cure is on the horizon. Unfortunately, our patient's status has been downgraded to *critical*.

I believe this hypothetical patient reflects the current state of our health care system. Amazingly, it has proven to be quite resilient—even in the face of multiple health system failures: coverage, access, cost, and quality.

With the housing and financial markets' collapse and with all economic indicators confirming domestic and global recession, the question arises, "How much time does our health care system have before it codes and cannot be resuscitated?"

Although the nation's current economic plight has garnered non-stop media coverage, the inextricably linked consequences affecting the health care system and ultimately the health of the nation have been, at best, glossed over. With the continued loss of jobs and employer-based health insurance, the ranks of the uninsured and underinsured have swelled. (In Wisconsin, over 27,000 jobs have been lost.[1]) Millions of Americans will go without medical care because they cannot afford it—while others will avoid care because they are mired in medical debt. Incredibly, 20% of the group forgoing care—both insured and uninsured—is comprised of working-age Americans.[2] Everyone talks about mortgage foreclosure, but no one is addressing the ever-increasing rate of personal bankruptcy—with unpaid medical bills accounting for about 50% of the total.[3]

There are many factors responsible for skyrocketing health care costs. For example, unpaid medical bills—free care—translate into physicians and hospitals charging higher fees to cover the lost operating revenue. This cost shifting is like a hidden tax: insurers pass it on to the insured by restricting benefits, increasing deductibles, and raising premiums. The federal government is by no means blameless in this area and must shoulder its fair share of responsibility. And yes, the unrealistically low reimbursement rates to physicians—primary care physicians specifically—

Dr Bergin is an OB/GYN in Stevens Point, Wis and president of the Wisconsin Medical Society.

have contributed to the unintended consequence.

Powerful supply forces that exist in our health care system also contribute to the problem. Physicians and hospitals can create and satisfy demand. Large costs are involved in treating acute events that result from lack of attention in preventing and treating chronic health problems. Pharmaceutical company direct-to-consumer advertising has fueled patient demand and expectations from physicians. But physicians, hospitals, and the pharmaceutical industry should not be held totally accountable. Americans' unrealistic expectations drive the use and overuse of expensive new technologies and treatment even where the application has minimal chance of a successful outcome. We have a society that pretends death is optional.

Following the birth and death of the Clinton Health Security Act, there have been only incremental attempts to deal with health care reform In short, the measures passed—Health Insurance Portability and Accountability Act, State Children's Health Insurance Program, and the Medicare Modernization Act have lessened the burden for some Americans but haven't come close to solving the vexing issues of cost, access, coverage, and quality. Given there were no new health care initiatives during the last 4 years of the Bush Administration, can we expect the new administration will offer a new direction in an attempt to reform an extremely complex system?

I believe the answer is an unequivocal yes. The pressure is on, as Congressional forces are quietly marshalling support for existing and developing initiatives. Senators Kennedy, Baucus, Wyden, and others are prominent among those looking to broker a political solution.

During the recent campaign, President-elect Obama's underlying theme was "America needs change," and he said that if elected he would be the instrument of that change. On December 11, former Senator/Majority Leader Tom Daschle (D-SD) was announced as the new secretary of the Department of Health and Human Services (DHHS). In the announcement, President-elect Obama said Daschle would not only be responsible for implementing a health care reform plan, but that he would also be the architect of the plan.

This announcement immediately raised several pertinent questions.

1. Does Senator Daschle's appointment as DHHS Secretary truly represent a change in health care reform policy?
2. Will we see a retooling of the failed Clinton Health Security Act?
3. What is Senator Daschle's philosophy now regarding health care reform?
4. Does he hold to the rigid ideology of the past or has he taken a more pragmatic view as to how to effectively pursue meaningful change?
5. What type of framework will he create for the US health system?

Answers to these provocative questions and a definite insight into Senator Daschle's current thinking on the health care reform issue can be found in his recently published book *Critical—What We Can Do About the Health-Care Crisis*.[4] When the book was released, President-elect Obama said "Senator Daschle brings fresh thinking to this problem," and "his Federal Reserve for Health concept holds great promise for bridging this intellectual chasm and, at long last, giving this nation the health care it deserves."

Senator Daschle's text highlights the current health care crisis and supports his perspective with tragic real-life examples of how the health care system has failed ordinary Americans. He traces the long, arduous history of attempted health care reform and points out mistakes made and lessons learned.

Rather than finger pointing and placing blame, he offers his vision for a reformed health care system and provides a blueprint that includes his key concept of a Federal Health Board (Board). (Daschle, 169-180) He proposes creating a Federal Health Board and charging it with developing the health care system framework, as well as the operational details. Its functions would include the following:

- Set the rules for the expanded Federal Employees Health Benefit Program
- Promote high-value medical care by recommending coverage of drugs and procedures backed by evidence based medicine
- Align incentives with high quality care—ie, pay-for performance based on adherence to evidence-based guidelines
- Play a role in rationalizing our health care infrastructure—ie, resource distribution based on geographical need

The Board would be quasi-governmental—an independent board insulated from political pressure and yet accountable to elected officials and the American people. "This would make it capable of making truly complex decisions inherent in promoting health system performance. It also would give it the flexibility to make tough changes that have eluded Congress in the past." (Daschle, 169)

The Board's Governors would be chosen based on knowledge and expertise in health care and would

be representative of health care stakeholders. Terms would be for 10 years—the President would appoint, and the Senate would confirm. Continuity would be established and conflicts of interest would be minimized.

Enforcement of policies would be outside the purview of the Board, as it would not be created to be a regulatory agency. However, recommendations would have teeth as federal programs would be required to abide by them. In effect, this covers one-third of the American population. The hope is that the Board's recommendations would spill over into the private sector and would be adopted there as well.

The following quotes from Senator Daschle's text support the notion that he is not a partisan ideologue and has embraced a more centrist viewpoint regarding health care reform.

- "We must stay focused on pragmatic solutions such as a Federal Health Board and reject rigid ideology."(Daschle, 198)
- "I have strong views on what an ideal system would look like. But I'm not willing to sacrifice worthy improvements on the altar of perfection."[2]
- "The tortuous history of health care reform in the last century illuminates our current predicament, offering lessons we shouldn't ignore if we want to finally fix our broken system." (Daschle, 45)

There are undoubtedly many cynics out there who, having read Senator Daschle's book, are not convinced as to what his true intentions may be. But that is the beauty of being a US citizen where we can question, disagree, and participate openly in the forthcoming national debate.

References

1. Boulton G. Health insurance after layoff. Unemployed should seek alternatives to COBRA if young and relatively healthy. *Milwaukee Journal Sentinel*. December 6, 2008. http://www.jsonline.com/business/35635084.html. Accessed December 11, 2008.
2. Kaiser Foundation. Medical debt and access to health care. http://www.kff.org/uninsured/upload/Medicaid-Debt-and-Access-to-Health-Care-Report.pdf. Accessed December 18, 2008.
3. Lambrew JM, Podesta JD, Shaw TL. Change in challenging times: a plan for extending and improving health coverage. *Health Affairs*. 2005. http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.119v1. Accessed December 18, 2008.
4. Daschle T, Greenberger SS, Lambrew JM. *Critical—What We Can Do about the Health-Care Crisis*. New York, NY: Thomas Dune Books; 2008.

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