

## Health reform bill will not contain costs – The Issue

Although a complex 2,000 page bill, the stark difference of opinion over the prudence of enacting proposed health reform legislation is quite simple. Everyone favors increased health care access and quality. This requires resources. If the bulk of these can be derived from cost savings promised by proponents of the legislation – without any diminution in current access and quality – the bill would enjoy universal support. Many believe they cannot.

Paying physicians and institutions less for the provision of *necessary* services is not an option. Each day the newspapers are full of patients already being denied services (e.g., Grady Memorial Hospital (a safety net facility) in Atlanta, Mayo Clinic in Glendale, AZ) because government insurance plans pay less than cost for certain services. Annually, the Nation's seniors and military dependents experience a crisis until Congress appropriates "band aid" funds for another year to defer planned reimbursement cuts (that would result in denial of care).

Improved administrative efficiency, automation, tort reform and reduced waste, fraud and abuse are all long overdue and welcomed. However, except for a few state and local efforts, despite many promises over the last several decades there are few success stories. Realistically, it is doubtful potential net savings (considering required bureaucratic expansion and the political reluctance to enact liability reform) will, under the best circumstances, contribute more than 10% of the needed resources.

Assuming that at least the Nation's current level of investment in biomedical discovery, education and delivery access will continue, 90% of savings, therefore, likely will need to come from reducing the consumption of certain health care services. There are two ways to do so, reduce consumer demand or practitioner/institutional supply.

Academicians and policy wonks have suggested huge savings are possible through the expanded application of evidenced based medicine and cost/comparative –effectiveness research to reduce the supply/ consumption of unnecessary, ineffective, more costly and wasteful services. As desirable as these approaches are, in the real world of medical practice – and until we realize considerable advancements in the practical application of "personalized medicine" (factoring into patient care the genetic, environmental, and social parameters of *each* unique individual) – the gains are greatly overstated.

Consider three common conditions that have recently received press coverage – back pain, depression and mammography screening. Vast differences in professional and public opinion exist over how these conditions should be addressed and whether these measures are being greatly under-utilized or over- utilized. The bottom line is that over the last few decades federal

and state governments have greatly expanded the scope and variety of services for which they provide reimbursement, not reduced it. There is no reason to expect this to change.

Equally overstated are the projected cost savings realized through providing uninsured and underinsured individuals *financial* access to effective preventive services and early primary care, theoretically obviating the provision of more costly care down-stream. A few preventive services have been shown to produce long term savings; many improve health status and the quality of life. However, it is not clear that broadly reducing financial insurance barriers is the most cost-effective approach to increase the number of individuals incorporating healthy life-style practices and recommended preventive and early primary care. Organizational delivery changes, altering physician supply and mix, and various other community programs and incentives, are likely to be much more effective and efficient. The reality is that less than 4% of *insured* American adults embrace the life-style practices recommended by CDC and about 40% fail to receive recommended effective preventive services.

Furthermore, such care might also prolong life expectancy and the consumption of additional services to preserve or replace various body parts and systems deteriorated through chronic use and disease. Such care might improve health status but actually increase resource consumption in the long run. Even the Congressional Budget Office is reluctant to claim cost savings from such measures.

As long as we remain fixated (as the legislation does) upon *central financial entitlements to services* - rather than *locally maintaining and improving health status* – there is little hope of consensus and solution. This requires we focus locally on individual, professional and public mechanisms and responsibilities to maintain and improve health status.

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