

Health reform – Dispelling Myths

July 2009

Recent developments (H. R. 3200 compromise) suggest national legislators are starting to acknowledge the need to address certain myths regarding health system reform. Others remain.

One admission is that controlling health costs by summarily limiting “government plan” reimbursements to below costs or fair-market rates should stop - a bad idea that produces chaos and rationing. The yearly Medicare crisis - panicking seniors and physicians - has documented this.

Furthermore, there has been a tacit admission that if a future public plan fails to reimburse at fair-market rates, this will lead to cost shifting, dropped private insurance coverage and public plan rationing. By requiring any public plan to pay at least Medicare reimbursement rates (although these are somewhat below market), the magnitudes of such outcomes are reduced.

Nevertheless, if government cannot control costs by other means – as they have been unable or unwilling to do for several decades – nothing prevents Congress from renegeing upon the above commitments in future years. However, they have made a major acknowledgement in this regard - dispelling the myth that Congress can successfully set reimbursement rates and otherwise directly control costs by reducing fraud, waste, and abuse resulting from the provision of ineffective, futile, and unnecessary care. They propose creation of a BRAC (Base Reduction and Closing) type board to accomplish this.

I view this as a positive development but have concerns about unwarranted assumptions and remaining myths that underlie the proposal. Despite little documentation, the myth persists that most waste is a product of health practitioners driving up the volume of unnecessary, expensive, and ineffective diagnostic and therapeutic procedures to benefit financially. Furthermore, a myth persists that expanded comparative - effectiveness research and the application of evidence-based medicine by such a board can essentially eliminate such waste. The proposal also assumes politicians will refrain from interference. The reality could be far different.

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”, we must rely upon population probabilities that often are not operational in certain individuals.

Treatment of depression is a case in point. The rate of this illness has remained at about 16% over the last few decades but the cost of treatment has skyrocketed. Advocates claim our investments in screening and treatments are still woefully inadequate, costing the nation far more in absenteeism, lost productivity and suicide. Moreover, there are over 20 different common medications used to treat depression with the best combination being a highly individualized determination. I support the expanded use of evidence-based medical practice but caution that the number of conditions lacking evidence or consensus as to the best screening, diagnostic, and treatment approaches is enormous.

A more troubling myth is that physicians largely – if not exclusively – determine such approaches. The fact is that with the advent of the internet and direct media advertising, patients have assumed a much greater role in such determinations. If their doctors and insurance companies respectively are unwilling to provide and pay for the treatment they desire, they are not hesitant to seek – largely through multiple advocacy groups – political interference to obtain such. There are many problems with private insurance companies, e.g., pre-existing condition exclusions, we need to fix but unwillingness to deny payment for ineffective care is not one of them. Failure to limit care causes a loss of profits for insurance companies but gains votes for politicians. Even more doubtful is the likelihood politicians and the judiciary will refrain from interference in ethical matters such as payment for futile care. Reducing personal and family monetary and social responsibility (and incentives) to obtain cost-effective care - while eschewing ineffective and futile care - introduces additional challenges.

My favorite case involves Lyme Disease. Connecticut Attorney General Richard Blumenthal recently investigated the Infectious Disease Society of America (IDSA), an esteemed medical organization, after they recommended against long-term antibiotic treatment for the condition and patients complained to politicians that insurance companies now were refusing to pay for such care. One could dismiss this as a rare fluke, except it has been a contentious issue for years. In my book, “De-Spamming Health – Reforming the Health System from the Bottom Up” I describe a case in the mid 1990’s where an NIH scientist was suspended by federal authorities when he challenged the clout of the Lyme Disease lobby for advocating non-scientific practices.

Dispelling various health system myths is welcome progress but we have a long way to go and many other issues to address, e.g., medical liability, local organizational integration, to reach the best solution for all Americans.

Copyright Notice – Copyright 2009 James D. Felsen, MD

(Published in “The Charleston Gazette”, August 17, 2009)