Health Policy in Medicine: Inside the Beltway

Hot Heads vs. Cold Facts: In the Doldrums of Health Care Reform

by Eugene Rich, MD, FACP

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August is always a strange time inside the DC Beltway. Congress typically takes a long recess; members (and their staff) use this time to take vacations and to return to their home districts to hear from their constituents. As a result, Capitol Hill is usually pretty quiet, seats are readily available at downtown restaurants (with no one to "lobby" the lobbyists take vacation too), and the news media need to find other sources for stories of conflict and carnage (Shark Week anyone?). Of course readers of this column will know August 2009 has not been a quiet time for national news. In town hall meetings and talk shows almost every conceivable charge has been leveled at health care reformers. Once you've accused our mixed race President (who was raised by his grandmother) of being a Nazi who supports legislation to "Kill Granny"- what else can be said?

As I've observed in previous columns, health care reform in the US is threatening and potentially painful to many special interests, and therefore hyperbolic attacks are hardly unexpected. With nearly 20% of the US economy now tied to health care (almost double that of the next most expensive health system- Switzerland), a stunning number of people and businesses are discomfited by efforts at reform. These stakeholders are very reluctant to willingly forgo future earnings; this inevitably includes doctors.

I've often heard the truism "Doctor's don't just work for money…" Medical students work hard during their clinical clerkships and pay startling amounts for the privilege. Residents toil many long hours at low pay for years before they complete their training. Once in practice physicians routinely take actions motivated by patient considerations rather than personal income, whether it's a busy surgeon seeing a walk-in, a critical care physician laboring into the wee hours on an uninsured ICU patient; or an HMO family doctor arranging a patient referral for bone marrow transplantation. With only the rarest exceptions, physicians intend to fulfill the professional ideal of altruistic practice.

Doctors don't just work for money, "…but it all looks like money to me." Physicians want to do important work worthy of their intellect and sacrifice, and they want their effort be appreciated by their peers and others in their community. So they want the best technicians, the latest equipment, the most effective workspace. And then there are the resources required to achieve community impact and work life control. All of this takes money. And among the reasons US health care is so expensive relative to other countries is how we get that money to physicians.

Reformers and economists observe ongoing problems with the "piece-work" style of fee for service payments that have long dominated US health care. In 1969, a family doctor would earn about 4 times the per capita GDP (a share of national wealth similar to what physicians earn in most industrialized countries today). At that time US surgeons and other specialists earned 25 to 30% more than GPs (4.5 to 5 times per capita GDP). This difference made economic sense given the additional years of training and (for surgeons) the extra time spent in "after hours" work (early morning, late at night, or weekend emergencies). In 2009 US physician payments have evolved dramatically. Surgical (and some medical) specialists can realize 200 to 400% more than the primary care physician, 10 to 20 times the income of the average worker. Thus many specialized US physicians earn vastly more than similar specialists in other wealthy countries (even countries whose health systems are not remotely "socialized").

And it's not just physicians who are expensive in the US health care system. The US pays a premium for many health care goods and services, from prescription drugs to MRI machines to technicians to health care administrators. If we are to bring long term health care costs under control, the US will have to control this excess spending in future years. The Obama administration and Congressional proposals describe mechanisms to "bend the curve" of inexorable cost growth, and in the process, rein in excessive payments on physician services and better reward effective, appropriate, high quality care. Since the anticipated "excess spending" is included in baseline projections for health care spending, this wise, albeit painful (for some doctors) plan to correct these payment problems counts as "Medicare cuts." This creates new opportunities for

opponents of health care reform to level false charges the legislation necessitates rationing, and “killing Granny.”

So this August has been a particularly strange time inside the DC Beltway. Reforming the byzantine US health care system is complicated and easy to misrepresent. To maintain affordable health insurance over the next decade will require changing incentives (and future earnings) for a lot of people, including doctors. And then there is expanding access to the 45 million (or more) uninsured. Our current health care system is not just inequitable but unsustainable. Let’s hope that the hot heads of August will cool in the coming weeks and Shelley’s observation holds true: “There is a harmony in autumn…”

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