

WHEN IT COMES TO HEALTH CARE, CAN'T WE GET ANYTHING RIGHT?

Lawrence I. Bonchek, M.D., F.A.C.C., F.A.C.S.
Editor in Chief



In the past few weeks we have witnessed two remarkable misadventures in health care: the mangled roll-out of the Affordable Care Act, and then the issuance of new guidelines for the use of statins—followed immediately by widespread controversy and many vows to disregard them. Both matters are relevant to important articles in this issue of the *Journal*, and I will address them in turn. (Though I have previously commented extensively on the implications of the Patient Protection and Affordable Care Act,¹ the ideological frenzy engendered by its roll-out begs further perspective.)

I. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

“You can always count on Americans to do the right thing - after they’ve tried everything else.”

This aphorism, widely but incorrectly attributed to Winston Churchill (disclosure: I have made the same error), is so often quoted that it has lost much of its impact or even charm. But in fact, clichés retain their visibility and become overused precisely because they offer obvious truths.

When it comes to health care, certainly, the U.S. has demonstrated a gritty determination to do everything but what other developed countries have done. In our attempts to deal with the deficiencies of our insurance-based system, we’ve done little more than tinker around its edges. Even the Accountable Care Act (ACA or Obamacare) retains private insurance as its basis. All other developed economies long ago abandoned such an arrangement as the basis for their systems, though most retain the option of supplemental private insurance for those who can afford it. The result of our persistence in pursuing market solutions is that—compared with systems in other developed countries—ours is vastly more expensive, has poorer outcomes, and is unavailable to large segments of the population. This is not a matter of opinion; a 2013 report from the Institute of Medicine stated flatly: “a

growing body of research . . . suggests that the health of the U.S. population is not keeping pace with the health of people in other economically-advanced, high income countries.”²

For cultural reasons, we have preferred our system because it preserves individual choice and the appearance of market competition. In fact, of course, the progressive amalgamation of both providers and payers has sharply constricted competition within service areas. Further, even our system’s former advantages of short waiting times and easy access to care (for the insured only) are rapidly disappearing, thanks to a developing doctor shortage and reimbursement models that focus on productivity. The difficulty of finding a physician with time to sit down and talk with patients has stimulated the growth of concierge care, in which patients pay a retainer out-of-pocket so they can be assured of having personal contact with their doctor whenever and however they request it—including email, text, and cell phone, or even in their homes.

As detailed in this *Journal* in June by Drs. Gates, Fogleman, and O’Gurek,³ “in comparison with 17 peer countries, the U.S. ranks at or near the bottom in most measures of health and longevity; life expectancy is lowest for U.S. males, and second lowest for U.S. females; U.S. death rates are fourth highest for communicable diseases, and second highest for non-communicable diseases. Although the mortality rate for ischemic heart disease has declined substantially in the U.S., it has declined more in our peer countries, leaving the U.S. with higher cardiovascular mortality than every peer country except Finland. Likewise, infant mortality has dramatically declined in the U.S. over the last 50 years, but remains higher than in any other peer country.”

All this is true even after making adjustments for race, ethnicity, immigration status, etc. As Gates and colleagues pointed out, the key determinant of differences among nations in the health of their peoples is not total national wealth, but rather income distribution.² In terms of the gap between the wealthiest and the poorest 10%,

the U.S. has a higher level of income inequality than its peers.* It should be no surprise that a system based on private insurance and paid for by individuals loses out in comparisons with countries that have some variant of a national single-payer health care system.

The conflict between America's political right and left is preventing rational discourse about how best to provide health care for our entire nation. Rather than debating the effectiveness of alternative means of solving a commonly perceived problem, many simply reject the need for major changes in the system. Increasingly, opposing views of the problem reflect one's view of government. Does one think that government is capable of solving societal problems, or—as Ronald Reagan famously said in his First Inaugural Address—government actually is the problem?

When it comes to health care, that question has a distinctive corollary. Even if one generally feels that the private sector and market forces are more effective and more efficient than the government's often ponderous and inefficient bureaucracy, one also must decide if that principle is true in health care where competition for market share often raises costs rather than lowering them.

To further distort the debate, many politicians and columnists have used the bungled ACA website as evidence of a bungled policy. By now, critics who reject the premise and principles of the ACA have so relentlessly attacked its initial software problems that the public might well believe the entire concept is irretrievably flawed. In truth it may be, but how do we know yet? Software bugs are common in new programs (even the great Apple has incurred them) and a poor website doesn't necessarily mean a poor policy. We can expect that the bugs will be corrected, at which point we will hopefully return to assessing the merits of the ACA.

Aside from these presumably temporary distractions, at the core we physicians must acknowledge that the present system cannot long endure because it is grotesquely expensive; does not provide access to everyone; and has outcomes that are heavily dependent on socio-economic status and ability to pay. From a purely moral perspective we should favor some system that extends coverage to the previously uninsured and uninsurable; to those with pre-existing conditions; and to those who cannot afford the premiums needed to buy a decent level of coverage.

It should be obvious that attempting to solve those problems in a system based on private insurance requires insurance companies to act against their own best interests. (And I mean all insurers. As I have previously explained,³ the difference between for-profit insurers and so-called non-profits, exemplified by the two types of Blues, often means little more than whether surplus revenues are distributed to stockholders or whether—at non-profit Blues—they can be used to hike executive compensation and to build fancy corporate offices so that no embarrassing profits remain. It is easy to be a non-profit; just be sure that you spend all surpluses.)

Furthermore, it is unrealistic to expect that health care costs can be controlled in a system as diffuse and unmanaged as our fee-for-service system. Though the ACA is likely to have some restraining effects on costs, its benefits are limited. To assure passage, the public insurance option that would have restrained premiums was gutted from the final bill. Insurers will continue to extract their \$.20 for overhead from every health care dollar. Other disadvantages of an insurance-based system are already beginning to emerge. The average individual deductible in the lowest priced (“bronze”) plan may be as much as \$5,000 a year, clearly prohibitive for those earning, say, \$35,000.

A variety of solutions for our health system's dysfunction have been proposed: vertically integrated systems with a capitated population, such as Kaiser Permanente;³ ACOs and other strategies for sharing risks and profits; and single-payer health care or, as it is often termed, Medicare-for-all. (These problems and possible solutions are being explored in a series of articles by Drs. Gates, Fogleman, and O'Gurek which began in an earlier issue² and continues in this one. If you missed the first I urge you to go back and read it; it's also online.⁴ The article in this issue is equally comprehensive and thought provoking. Also, look out for the exciting conclusion in a future issue.)

There are no flawless solutions to life's major challenges, and the search for perfection always ends in disillusionment. When confronting a major choice in life—whether selecting a potential employee, job, home, vacation spot, etc.—it is wise to look for the inevitable flaws in each choice and then to decide which flaws one can live with. From that perspective, I would expect that single payer will

* Switzerland's banks harbor deposits that reflect great wealth, and it is home to 5 of Europe's top 20 best paid CEOs, but it has greater income equality than the U.S., Japan, the U.K., and Canada. In a recent national referendum, a proposal to limit executives' pay to 12 times that of junior employees was rejected by a vote of 65-35%. (Swiss income equality is not due to relatively low pay at the top, but rather high pay at the bottom.)

eventually emerge as the arrangement with the most tolerable flaws. It already has many silent advocates, and some prominent ones who are not shy about their views.

Physicians for a National Health Program (PNHP.org) promotes a comprehensive single-payer national health program. In existence since 1987, it claims 18,000 members and chapters nationwide. Oft-quoted Dr. Steve Nissen, Chair of the Department of Cardiovascular Medicine at the Cleveland Clinic, was recently asked by MedPage Today "What's the biggest barrier to your practicing medicine today?" His answer: "The lack of a single-payer system. We waste enormous amounts of time and energy dealing with insurance companies, whose major goal is figuring out how not to cover patients." This from a doctor who works at a huge multi-specialty clinic where he is insulated as much as possible from actually having to wrestle with reimbursement from individual patients!

Even with this growing support for single-payer, however, a revolutionary change in health care delivery is unlikely to occur unless the public demands it. For that very reason, however, I expect that single-payer is the system most likely to be accepted when the public demands change because Medicare is successful and popular.

Medicare is effective, however, only in assuring access to care and affordability for the consumer. Since it works through the traditional fee-for-service system, it is not nearly effective enough at cost control. Medicare expenditures are now 13% of the entire Federal budget and it is only serving a fraction of the population. A single-payer system for all cannot retain fee-for-service in its current form. This may seem bitter medicine for physicians, but I expect that reality will force us to swallow it.

2. STATINS: ARE THEY NOW MORE COMPLICATED OR LESS SO?

Recently a combined committee of the American Heart Association and the American College of Cardiology issued new guidelines for the use of statins to lower the risk of cardiovascular disease. These

departed from the conventional approach of treating elevated cholesterol to goal, and instead offered a risk-calculator to guide treatment, particularly of healthy patients who would otherwise not be treated. As is well known, the guidelines came under attack immediately for potentially overestimating risk and leading to a dramatic (and possibly unnecessary) increase in the number of patients taking statins. The basic outlines of the controversy are well known to physicians. As is often the case, an insightful and knowledgeable science writer has carefully digested all the conflicting opinions and provided a useful article for physicians that could be helpful in explaining this mess to patients. I commend to you the article in Time by Alice Park.⁶

Even more, I commend to you the extraordinarily comprehensive article in this issue by Dr. Scott Deron on Practical Lipid Management and the Role of Advanced Lipid Testing. In addition, the accompanying Position Statement from The Preventive Cardiology and Apheresis Clinic of The Heart Group of LG Health provides an up-to-date perspective on the new guidelines and guidance on how to react to them.

ALSO IN THIS ISSUE

In addition to the two articles mentioned in this editorial, this issue contains a wealth of additional information. Dr. Christopher Shih discusses the crucial role of gut flora and our growing understanding of their importance in various disease states, and Drs. Mark Werley and John Briguglio discuss the use of the Transjugular Intrahepatic Portosystemic Shunt (TIPS) for treatment of symptomatic portal hypertension. Finally, Dr. Alan Peterson provides his regular column of unique insights and updates.

I also draw your attention to the updated and expanded call by Dr. Rupal Dumasia and colleagues for patients to participate in a study of renal denervation therapy for refractory hypertension which now need only be moderate rather than severe. Full details and a phone number for referrals will be found in the article.

REFERENCES

1. Bonchek LI. A modest proposal for health care reform. *J Lanc Gen Hosp*. 2012; 7:65-67
2. Institute of Medicine Committee on the Learning Health Care System in America. Better Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, D.C.: National Academies Press, 2012. www.nap.edu/catalog.php?record_id=13444
3. Gates, T, Fogleman C, O'Gourek D. A primary care perspective on U.S. health care: Part 1: the good, the bad, and the ugly. *J Lanc Gen Hosp*. 2013; 8: 37-43
4. www.jlgh.org/Past-Issues/Volume-8---Issue-2/Primary-Care-Perspective-on-US-Health-Care.aspx
5. www.medpagetoday.com/PracticeManagement/PracticeManagement/43257
6. healthland.time.com/2013/11/20/should-i-take-a-statin-what-you-need-to-know-about-the-new-cholesterol-guidelines/