Diagnosing the Obama Plan

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Editor's note: This article was submitted in October 2009 and may not reflect the Obama Plan at the time of publication. It is provided here to stimulate discussion surrounding public health systems.

In discussing opportunities of crisis, Rahm Emanuel, Barack Obama's Chief of Staff, stated, "you never want a serious crisis to go to waste," implying that crisis provides an opportunity to do things that could not be done otherwise. The current economic recession has provided the Obama administration an opportunity to tackle healthcare reform, which has resurfaced for the fifth time since World War II.[1]

Healthcare reform is currently a fiscal imperative given the rising costs of healthcare and the dismal economic climate. In 2007, the United States spent $2.2 trillion, or 16% of the gross domestic product (GDP) on health care, figures that are projected to reach $4.4 trillion or 20.3% of GDP by 2018.[2] Between 1999 and 2008, average health insurance premiums have increased approximately 120%.[2]

> "The Obama plan fails to envelop the most important cost control mechanism evident internationally —cost containment by setting caps on healthcare expenditure

High insurance premiums coupled with the economic recession have led to massive layoffs and cut backs on the employer-sponsored insurance system, which covers 60% of Americans.[3,4] The high costs of health insurance premiums have left more than 45 million Americans uninsured and subsequently, placed an increased demand for government-sponsored insurance programs, like Medicaid.[5] However, in order to qualify for government-sponsored insurance programs, stringent criteria must be met: "Medicaid ... does not provide health care services, even for very poor persons, unless they are in one of the designated eligibility groups"[6] This has created a fiscal dilemma for the government to provide more funds while tax revenues continue to decline. The fiscal emergency works in favour of Obama's administration to entice changes that will control the healthcare costs. The Obama plan intends to control costs by improving medical practices and health outcomes along with restructuring the health insurance marketplace.[3] The purpose of this paper is to examine whether the Obama plan contains significant cost-control measures.

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CUTTING COSTS BY IMPROVING MEDICAL PRACTICES AND HEALTH OUTCOMES

The Obama plan proposes to control costs by accelerating the adoption of Health Information Technology (HIT), establishing a comparative-effectiveness research institute to generate information about effective treatments, promoting better disease management, emphasizing prevention and public health, and changing the payment system on the basis of performance and outcome.[6]

Although these reforms are certainly desirable in theory, evidence suggests that they are unlikely to reduce health care costs. The Obama administration has guaranteed an investment of $50 billion in HITs, including investment in electronic medical records, because of its potential to increase efficiency and quality while lowering costs.[6] By allowing easier exchange of information between healthcare providers, the interoperable electronic medical records can generate savings by reducing duplication of diagnostic procedures. However, the Congressional Budget Office (CBO) report refutes the claim that HITs will result in significant savings because of the current fee-for-service payment system. If providers reduced costs by providing fewer or less expensive services, they would submit lower charges to both public and private health insurers, which will subsequently decrease their revenue. Therefore, the current organization of healthcare financing and delivery provides no real incentive for effective utilization of HITs.[7,8]

Similarly, "re-alignment of incentives [such as changing the fee-for-service payment system] is a precondition for the successful application of CEA [cost-effectiveness-analysis]".[9,10] "Information by itself is not enough".[10] In other words, savings from cost fee-effectiveness research depends on whether insurers translate research into medical practice by changing coverage decisions. The CBO report estimates that comparative-effectiveness research might reduce healthcare spending by only $8 billion over the period of 2010 to 2019, less than 0.1%.[11]

Furthermore, many studies have shown that the potential of preventive medicine to decrease costs is often over exaggerated.[3] Public health advocates argue that if doctors detected conditions in their early stages, before they require more costly treatment, healthcare costs would also decrease. However, a retrospective review of 599 studies published between 2000 and 2005 showed

that 80% of preventive services increased total costs of care.[12,13] In the review, Louise Russell, a health economist, concluded that "over the past 4 decades, hundreds of studies have shown that prevention usually adds to medical spending."[12] Only 20% of preventive strategies, which include childhood immunizations, smoking cessation advice, and prenatal care for at-risk mothers, were cost saving.[12,14] This is primarily because preventive strategies, in order to be effective, require patient compliance for behavorial modification, a difficult task to accomplish. It is desirable to promote behavorial changes that reduce associated morbidities, yet it is unclear what public policies will "force" the population to adopt healthier habits.[3]

Lastly, the cost reduction potential of Pay for Performance (P4P) strategy remains unclear.[3] The P4P model rewards health care providers who meet certain efficiency and quality performance targets.[15] By providing financial incentives for physicians, the P4P model attempts to encourage physicians to deliver high quality care. This model is already underway in the United States and the United Kingdom. However, further studies are needed to determine its cost reduction potential.[15,16]

RESTRUCTURING THE HEALTH INSURANCE MARKETPLACE

The Obama administration aims to control costs by restructuring the health insurance marketplace. Plans call for creating a new government-sponsored health insurance plan (similar to Medicaid) and a National Health Insurance Exchange (NHIE) with new market regulations. Both options would be open to Americans without access to public insurance or group health insurance.[17]

The public plan can theoretically decrease costs in three ways. Firstly, it can lower administrative costs associated with delivery of healthcare as seen in Medicaid. Secondly, by having large purchasing power, it can contain costs by restraining prices of the medical services it finances. Lastly, the low costs of the public plan can create true competition within private insurance companies to innovate in new ways that reduce costs.[3,18] It seems highly unlikely that the public plan will dominate the healthcare market; however, it has the potential to greatly influence the private market.[18]

The creation of NHIE would allow for restructuring of the private insurance marketplace. The central dogma of insurance is to pool risks within a population in order to protect individuals from significant contingent losses. Pooling individuals with diverse health statuses results in greater risk and cost sharing; individuals with large expected-healthcare needs are able to share the costs with those who anticipate little need for medical care.[19] Currently, many insurance providers in the United States distribute insurance on a state-by-state basis with the insurance pools consisting solely of individuals from a single state. By creating NHIE, a large national purchasing pool, the Obama plan will allow for a larger, more diverse pool of individuals such that both the costs and risk can be shared broadly across all insured individuals.[19] This will provide affordable insurance to a larger population and decrease risk segmentation.

Medical underwriting facilitates risk segmentation by providing insurance companies with the information to decide how high to set insurance premiums or when to deny coverage.[19] The process of risk segmentation is associated with high administrative costs that are directly passed on to the consumer, thereby increasing the costs of medical insurance. By creating a diverse pool of individuals, NHIE can decrease administrative costs associated with risk segmentation.[3,19]

But in order for risk sharing to be effective, the Obama plan requires an individual mandate compelling all adults to purchase insurance, thus creating a diverse pool. Because no such mandate exists, some healthy adults might opt out of insurance to avoid paying premiums, resulting in less risk sharing.[19]

DISCUSSION

Although making investments to improve medical practices does not show great potential in cost reduction, restructuring the insurance marketplace seems somewhat promising. Nevertheless, the Obama plan fails to envelop the most important cost control mechanism evident internationally —cost containment by setting caps on healthcare expenditure.[3,20] Consider Canada as an example. Since healthcare costs are primarily on the public budget, the government has a strong incentive to cap healthcare expenditure, thereby limiting the medical industry's continuous efforts to increase prices.[20,21] Without capping healthcare expenditure, effective cost-control cannot be achieved, and just as Medicare and Medicaid costs have risen historically, the costs of delivery of health care will continue to escalate.[3] Credible cost-control strategies are politically a hard sell because of the power medical industries hold, as apparent by the demise of the Clinton healthcare reform plan of 1994. Setting a cap on healthcare expenditure threatens the medical industry's income, and those working in the industry have significant political clout in the United States. The Obama plan, as described by Marmor and colleagues, is merely an "illusion of painless savings…[making] the acceptance of cost control realities all the more difficult".[3]

Would it be prudent to embrace the Obama plan with its benign cost-control measures or should we wait for a "plan" that incorporates effective cost-control strategies as outlined above? Introducing ideas such as global budgets and spending caps at this time can be controversial. It can sink the entire reform effort because it will inherently elicit alarms of "rationing" of care from the medical industry.[3] The strength of the Obama plan is that it increases access to health insurance and has the potential to decrease the percentage of uninsured Americans from 17% to 6%.[19] More coverage will provide security for a greater number of Americans and can increase public support for the Obama administration. Only after gaining public confidence and some control of the healthcare market may the Obama administration draft reforms that include credible cost-control mechanisms, price restraints and spending targets.

CONCLUSION

Healthcare reform is not a one-time event; it is a process requiring a series of interventions to heal the current "bloated, Byzantine, and slowly bursting" United States healthcare system.[22] If the Obama administration was to incorporate rigorous cost-control

mechanisms now, the entire reform effort will likely be defeated. Now is the opportunity to start "treating" the United States healthcare system; let's not allow the opportunity this fiscal crisis presents to go to waste.

In addition to strengthening the ailing American healthcare system, the Obama plan has important implications for other developed countries. Many developed countries are dealing with similar issues of escalating healthcare costs while trying to provide equitable access to high-quality care, and Canada is certainly not an exception. As healthcare is becoming the most expensive social program, Canadians are grappling with the issue of public versus private insurance financing. The geographical proximity of the United States and Canada, along with their highly integrated economies means that United States' healthcare reform will undoubtedly have significant future implications for Canada.

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Teaching Socially Responsible Medicine in the Himalayas: A Lofty Pursuit

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Nine years ago at a hospital in Kathmandu, Nepal while on Intensive Care Unit rounds with Dr. Arjun Karki (a Nepali–trained doctor), we stopped at the bed of a twelve-year-old girl whose foot had been amputated that morning as a result of a car accident. I asked Arjun, "What will become of her?" Perhaps she would have to get a prosthesis, or have to use a cane? Arjun looked at me with troubled eyes and said, "Her chances are actually quite limited." He explained that the infection could get worse (indeed she lost half her leg later that day). Furthermore, because she was from a poor, rural district with no medical facility, her parents would be unlikely to afford the necessary medical care that Dr. Karki initiated in the city.

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Dr. Karki's statement pointed to the reality of how in some parts of rural, mountainous Nepal, the ratio of patients to doctors is 150 000 to 1. How is that possible in a country where more than 1000 new doctors graduate each year from 12 medical schools? A problem with retaining physicians in the country is one explanation, as 80% of the graduates will write licensing exams for practice in other countries. For those who stay in Nepal, they opt to practice close to, or in, the city of Kathmandu.

Last year the Kathmandu Post advertised 54 positions in rural district clinics. 25 applications were received, 22 applicants showed up for interviews and 12 were offered positions.[1] According to Dr. Karki, less than 50% of those offered positions actually showed up for the district jobs.

What is partly responsible for these grim statistics is the fact that current Nepali medical schools are mostly for-profit, and