

Commentary on “Health Care Crisis: Systems Insight to a Practicable Approach”

by Mitchell T. Rabkin, M.D. and John S. Cook, D.Phil

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Drs. Rabkin and Cook present an articulate and reasoned contribution to the current debate on reshaping the health care system. The problems they address — notably costs, quality of care, and patient and physician satisfaction — are tightly interrelated and are certainly lead issues. There is wide agreement that significant impacts on all three, especially costs, will require major changes.

What is presented is a market approach through a new Medicare product. The proposal seeks to enhance the role of the primary care provider, largely the generalist physician, as the focal point in care and in cost control by introducing a more structured practice pattern and by reducing the pressures behind high throughput practice patterns. It thereby encourages less hurried and presumably more effective and more satisfying care. The idea is to structure clinical practice around these providers of first contact and ongoing general care by assembling them in small teams, caring for more or less committed panels of patients (although an opt-out provision is included) and through referral networks and hospitals connected to these teams of physicians

in a manner that is not specified. All of this is based on patient panels of a size that is actuarially sound, with risk-adjusted capitated payment, global budgeting, and substantial financial incentives for effective cost control, improved quality of care, and enhanced patient satisfaction. On the patient's side, financial incentives for coming into and remaining in the system are also offered.

Certainly there is ample evidence that inventive new approaches are needed. Health care costs are clearly out of control, currently consuming nearly 17 percent of the gross domestic product (GDP). Medicare itself consumes 4 percent of GDP and represents 19 percent of health care spending, some \$400 billion annually at present. Part D, the prescription drug coverage segment of Medicare, accounts for about another \$40 billion. In addition, health care spending growth is expected to outpace GDP growth by an average of 1.9 percentage points annually, so that by 2017 about 20 cents of every dollar spent in the U.S. economy will be spent on health care. By any measure, this is an unsustainable trend.

The presumption is that the authors' plan will help to reverse this trend by making primary care practice more attractive. Certainly the time for significant change appears to be more propitious than in many years. But what is missing in the plan presented? As powerful as it may be in addressing costs and related issues in quality, the market approach does not come to grips with other major problems. First, physicians are shunning primary care careers, presumably due in some measure to low reimbursement levels, resulting in high throughput practice patterns and resultant dissatisfaction with their ability to deliver thoughtful, unhurried care — although the content of primary care practice may also be an important determinant. A fundamental problem is the distorted health care workforce we have developed through a pattern of vigorous and unrestrained subspecialization at the expense of sophisticated generalist care, particularly in

internal medicine — a model that would embrace not only primary levels of care but more complex disease at secondary and tertiary levels as well. The emergence of the resulting primary care paradigm has in some degree, it may be argued, aggravated the cost problem by promoting subspecialist referrals and the high-technology practice patterns associated with subspecialist care. And, at the same time, it has moved much of the complexity and challenge of generalist careers to subspecialists. None of the policy options currently under discussion addresses this complex set of key issues.

In addition, although prevention as a major component of high-quality health care has been mentioned by many, specificity is generally lacking in the plans that have been offered, and particular incentives for physicians to increase their activities in disease prevention are not included in the present plan. In light of the fact that chronic diseases constitute the bulk of our health issues, accounting for 70 to 80 percent of health care costs, and since there is now a sufficient information base to allow much more widespread and effective pervasive efforts than in the past, this aspect of care should be emphasized and specified in this and any other suggested rearrangement.

Some of the assumptions underlying the proposal offered by Drs. Rabkin and Cook require closer examination. One is that cost control under their plan will result in enhanced quality of care. Another is that the cost control elements in the system will apply not only to the primary care providers but to their referral networks of consultants, or that these will have been selected on the basis of some type of agreement that includes cost control and that incentives will be offered to help this happen. But these arrangements are not spelled out. Third, the cost of Medicare Part D coverage for prescription drugs is unaddressed. Even in its present incomplete

form, Part D accounts for 10 percent of Medicare spending, and as its defects are addressed these costs are likely to rise sharply.

Finally, will the plan work? That is, if the suggested plan were put in place would we see some blunting of the rate of increase of Medicare costs? And would we see related enhancements in quality of care? The first of these seems not unlikely, the second murkier. Overall, the plan makes as much or more sense than many of the other system arrangements offered to this point. It can be tried and evaluated, and seems a reasonable experiment. Some type of fit inside current Congressional reform efforts would need to be worked out; introducing the plan would enrich those discussions.