Editorials

The AAFP Access Plan: Getting It Almost Right

The recent proposal from the American Academy of Family Physicians (AAFP) contains many recommendations for health care reform that I can wholeheartedly support.[1] The AAFP recommends universal health coverage, incentives to increase the number of primary care physicians, serious cost-containment measures (based largely on managed care), tort and insurance reform, and new mechanisms for quality assurance. With all these positive features, some of which appear quite daring, it might seem churlish to quibble with the proposal. Nevertheless, I wish in this editorial to make a case for the AAFP having included at least a willingness to consider a single-payer system for the United States, alongside of its preferred financing mechanism, the so-called "play or pay" mix of employer- and government-based coverage.

Virtually no one any longer defends our present nonsystem of providing health care, but there are a great number of competing proposals for reform. One widely acknowledged goal of reform is to decrease the administrative overhead costs of our present collection of between 1500 and 2000 third-party payers, both governmental and private. The present system drives up administrative costs in two ways. First, more employees are needed to process all the different insurance forms that must be sent to all the different payers. Second, more employees are needed to track each item of care and supplies dispensed to be sure the bill goes to the correct payer for that patient.

The AAFP plan would eliminate much of the first sort of waste by mandating a uniform set of insurance forms and protocols. But the plan would do less to remove the second sort of waste, which would be completely eliminated only with the adoption of a single-payer system, accompanied by global annual budgets for such institutions as hospitals, nursing homes, and health maintenance organizations.

Why should family physicians quibble about administrative waste so long as the impact upon them and their office staff — the "hassle factor" — is reduced by adoption of a uniform billing system? There is an overriding moral reason: Money spent on administration of the health care system is money not available today to extend coverage to those who lack insurance. Even if universal access were mandated, money spent on administration is money not available to expand the basic package of services that will be offered to the poorest citizens, who will lack the funds to buy extra insurance benefits. Administrative costs, by definition, do not expand the actual health services provided. Indifference to these costs is indifference to how much care the least-well-off citizens will receive from the health system.

There is another reason to be skeptical about play-or-pay. The apparent goal of this mixed private-governmental proposal is to retain some degree of consumer choice and some element of market competition while using appropriate regulations to assure fairness and universal access. (Leave aside for the moment that many forms of single-payer systems offer considerable choice to the individual consumer and that the experience with competition-driven health care reforms in the 1980s produced little evidence that they will substantially improve efficiency.)

Experience with the private marketplace in US health care to date suggests, however, that play-or-pay is a double bind. To allow full scope for consumer choice and market competition, the system would need to be unregulated to a degree that would threaten universal access and the adequacy of the basic care package, as private payers seek to capture the well-off market and not get stuck with paying for the highest cost patients. By contrast, to really assure fairness and universal access, the degree of governmental

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regulation would be so strict as to jeopardize any features of market competition that remained.

The AAFP plan, to my reading, leans toward the side of increased regulation, and this direction is fully defensible. But, if one has gone that far, what reason remains to continue to put up with the inefficiency of a multipayer system? One has gone virtually all the way to government-mandated and government-regulated health care, so why not adopt a single-payer system and accrue the monetary benefits of that system instead of just paying the political and economic costs? The only reason, it would seem, not to take that last step is the attraction of the ideological veneer of "private enterprise." Is that veneer worth, say, $50 billion in excess administrative costs that could otherwise have gone into better care for the underserved?

The AAFP has done us a great service with its bold and well-reasoned proposal. We must now take the debate forward and proceed to refine the proposal along with the political action required to get meaningful and thoughtful health care reform on the public policy agenda.

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References

1. Rx for health: the family physicians' access plan. Kansas City, MO: American Academy of Family Physicians, April 1992.

Clinical Guidelines And Primary Care

This issue of *JABFP* inaugurates a new feature, "Clinical Guidelines and Primary Care." The last several years have seen a flurry of attention to the process of medical care, with a growing number of clinical guidelines or policies developed and disseminated by many organizations in the United States. The list of groups involved in the clinical guideline business now includes the National Institutes of Health, the Agency for Health Care Policy and Research, and many specialty societies and groups, including the American Academy of Family Physicians with its own Clinical Policies Task Force. The Institute of Medicine has been actively involved through a committee to advise the Public Health Service on clinical practice guidelines, and its recommendations were released in 1990.[1] Increasingly, published clinical guidelines are finding their way into monographs and both general and specialty clinical journals, where they frequently encounter mixed reactions among clinician readers.

The Institute of Medicine has observed that diversity in clinical practice can range from acceptable to unacceptable, that well-constructed clinical guidelines can help to illuminate what is acceptable, and that these assessments can change over time. Its report points out that diversity in clinical practice may be acceptable "when the scientific evidence to support different courses of care is uncertain" and that "some degree of diversity may be warranted by differences in individual patient characteristics and preferences and variations in delivery system capacities related to locale, resources, and patient populations." On the other hand, "diversity in practice is unacceptable when it stems from poor practitioner skills, poor management of delivery systems, ignorance, or deliberate disregard of well-documented preferable practices."[1,pp 104-5]

The potential advantages of clinical guidelines, as well as their problems, are legion. To the extent that they can represent mainstream medical care under specific circumstances based on current scientific evidence, they can be useful in medical education, quality assurance, and encouraging improved standards of delivery of health care services. On the other hand, there are many steps along the way in the creation of clinical guidelines that could lead to compromise or even invalidate their application in everyday practice. There is a common tendency, for example, for such guidelines to be developed by "expert consensus," based more on opinion and global judgments than on objective assessment of available scientific evidence. Add the absent or nominal participation of primary care physicians to this process, and it is no surprise that many clinical guidelines being released today seem to lack validity and relevance to the diversity and complexity of primary care settings.

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