Health Policy and the Future of Health Care Reform

Howard K. Rabinowitz, MD

During the past 2 years, an extraordinary national debate took place regarding the US health care system, and despite the lack of any comprehensive federal health legislation, patients, providers, and government were all forced to scrutinize the benefits and shortcomings of our health care system at a level never before seen in this country. Because the basic and fundamental problems that forced health care to the top of the national agenda—cost and access—will not lessen, there is likely to be continual debate about US health policy in the foreseeable future. It is absolutely critical, therefore, for physicians and other health care providers to remain knowledgeable about these health policy issues.

The Journal of the American Board of Family Practice has therefore decided to begin a new feature related to this important topic. To inaugurate this effort, I would like to share briefly my own recent experiences in the health policy arena, as well as to provide an overview of the critical federal legislative issues that will likely be discussed during the next few years. Future issues will be devoted to addressing more specific policy topics, and will be solicited from individuals with national health policy experience.

The Robert Wood Johnson Health Policy Fellowship

During the 1993-94 year I had the opportunity (along with five other health care professionals) to participate in the Robert Wood Johnson Health Policy Fellowship. This fellowship, established in 1973 and administered by the Institute of Medicine of the National Academy of Sciences, consists of a 1-year program of orientation and full-time working experience in the nation's capital. Because of the remarkable nature of the legislative agenda—comprehensive health care reform—an added attraction was to be intimately involved with the national health care reform debate.

The health policy fellowship began with an intensive 11-week orientation program structured as a series of three to four seminars each day (more than 150 in all) with many of the individuals and organizations in Washington who influence and help formulate national health policy. I then spent the remaining part of the fellowship year working in the personal office of Senator John D. (Jay) Rockefeller IV (West Virginia), the perfect practical complement to the orientation. Working in a Congressional office was a challenging and markedly different experience from working as a physician or on a medical school faculty. Daily activities included writing background and policy memorandums, all related to health care, and helping Senator Rockefeller prepare for his daily meetings, hearings, speeches, and trips to West Virginia. I participated in writing speeches, helped brief the Senator for the Finance Committee hearings, and staffed the Senator at speeches, daily meetings, and committee hearings. I also met with a number of constituents from West Virginia each week, as well as with numerous lobbyists.

Because of the broad nature of the health reform process during 1993 and 1994, Senator Rockefeller's office was involved with a wide range of policy issues (Table 1). I had the opportunity to be primarily involved in many of those issues that directly affected the medical profession and medical schools. In addition, I had the opportunity to work with Senator Rockefeller in developing and refining the Health Professions Workforce section of the health care reform bill that was presented in the final weeks of the Congressional session by Majority Leader George Mitchell. This section included reform of the nation's graduate medical education system and support for academic health centers and medical schools. It provided for a national mechanism to

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From the Department of Family Medicine, Jefferson Medical College, Philadelphia. Address reprint requests to Howard K. Rabinowitz, MD, Department of Family Medicine, Jefferson Medical College, 1015 Walnut Street, Suite 401, Philadelphia, PA 19107.

Table 1. Health Care Reform Issues.

Academic health centers	Information systems
Access to specialty care	Insurance market reforms
Administrative reform and simplification	Long-term care insurance
Antitrust	Malpractice
Any willing provider	Medicaid
Auto insurance	Medical research
Benefits packages	Medicare
Centers of excellence	Nursing home care
Confidentiality of patient information	Premium caps
Early retirees	Prescription drug benefits
Employer mandates	Public health infrastructure
ERISA	Purchasing groups, cooperatives
Experimental treatment	Quality of care
Financing	Risk adjustment
Fraud and abuse	Tax caps
Health plan standards	Underserved (rural and urban)
Health plans	Worker's compensation
Home health care	Workforce

ERISA – Employment Retirement Income Security Act

control the total number of physicians being trained while also increasing the number of primary care physicians, an all-payer fund to support residency training in this country by having all health care insurers share equally in the cost of graduate medical education, and increased funding to medical schools earmarked specifically for ambulatory and primary care education. This section of the senate majority leader's bill was the result of negotiations with other key senators, as well as a large number of outside medical organizations, and was supported by the Association of American Medical Colleges, representing all of the medical schools and teaching hospitals in the country. On the other hand, the workforce section of the Mitchell bill was strongly opposed by New York Senator Daniel Patrick Moynihan,[1] who argued against the measure on the Senate floor:

> This is hubristic. This invites the wrath of the gods. This invites the death, the closing of a great moment of medical decision, unprecedented on earth. In the history of medicine, no such thing has happened in the advances of the last 30 years made in the United States. This is . . . a sin against the Holy Ghost.

Ultimately, this section of health care reform died with the overall demise of health reform legislation.

Finally, I had the opportunity to work with Senator Rockefeller to develop legislation creating a Center for Primary Care Research within the Agency for Health Care Policy and Research, which Senator Rockefeller introduced in the final days of the 103rd Congress.

The Washington Perspective on Family Medicine and the Future of Health Care Reform

One issue that became immediately apparent upon moving to Washington was the lack of a major presence of family physicians in the area (despite the truly impressive work of the Washington office of the American Academy of Family Physicians, which commands substantial respect and influence in the legislative arena). In large part this lack of presence is because the metropolitan Washington physician workforce is among the most heavily subspecialized in the country. As a result, few legislators, congressional staff, or their families are cared for by family physicians, which has a major impact on how they view the specialty.

Regarding the future of health care reform, the prevailing wisdom seems to be that (1) health reform is dead, (2) there will be no federal changes in health reform, and (3) most of the changes in health care will occur at the state level. Although these assumptions are partly true, they do not accurately reflect what is happening.

First, while comprehensive federal health care reform will not take place in the foreseeable future, there is a revolution going on in the marketplace—unmanaged competition—that is reforming health care faster than any governmental action would have done. Second, there will be major changes in federal health care legislation during the next few years, but these changes will primarily be in the form of budget cuts. Finally, states will attempt to reform health care and in some instances will make minor changes, but they will be severely hampered by the same budgetary and political issues that are occurring at the federal level, as well as by the difficulty of Congress to change the ERISA (Employment Retirement Income Security Act) laws.

Beginning in early 1995, the current Congress quickly made the switch from discussing health reform to discussing the future of entitlements. Health policy became entirely budget driven, with continual talk of tax cuts, budget cuts, deficit reduction, and a balanced federal budget. Health care was not even in the Republican Contract with America. Incremental reform issues (eg, pre-

existing conditions, portability) that everyone professes to agree on could remain difficult to address, because these changes provide increased health care access for so-called "high-cost" individuals and will therefore increase everyone's insurance premiums and possibly increase the number of uninsured.

The Medicare program, which is projected to face bankruptcy in 2002, is being targeted for major reductions, many of which will affect providers. At the time of this writing, congressional plans include $270 billion in Medicare cuts during the next 7 years, while President Clinton has proposed approximately one half that amount.[2] In addition, there is strong pressure to expand the Medicare managed care program. Furthermore, with both the Inspector General's Report (Department of Health and Human Services) and PROPAC (Prospective Payment Assessment Commission, which advises Congress on these matters) having recommended substantial cuts in the indirect medical education funding for graduate medical education (GME), federal support of residency training is likely to decline considerably during the next few years.

Likewise, most states have either obtained or are applying for 1115 waivers to implement Medicaid managed care programs, while Congress is discussing "capping" Medicaid and transferring it to the states in the form of block grants. Title VII money, which heavily supports family medicine teaching programs, is also up for reauthorization.

All of this activity indicates that, as opposed to 1993-94, Congress will likely implement major changes in federal health policy during this 1995-96 legislative session! Irrespective of the final outcome of the 1995 budgetary process, however, the strong pressure for continued reductions in federal spending for health will continue in future years.

Recommendations

Although Congress has abruptly switched its legislative agenda away from comprehensive federal health care reform and toward budget-driven cuts in health care programs, providers need to maintain perspective about what is happening. In the first place, despite the inevitability of some program cuts, the more deliberative Senate and the effect of presidential politics are likely to moderate the more extensive changes made in the House. Nonetheless, there will be a major downsizing in federal health care financing, which will likely continue for at least the next few years, and the government is unlikely to protect physicians and hospitals from the pressures of the marketplace.

On the other hand, what gets cut and how much gets cut are policy decisions of importance equal to what gets added. It is therefore critical for patients and physicians to address these issues with enthusiasm and energy. Whether Medicare and Medicaid are cut by $10 billion, $100 billion, or $400 billion—and whether these cuts are made to beneficiaries, home health programs, hospitals, or physicians—has enormous impact on patient care. The distribution of cuts in public welfare, public radio, or public health care is likewise critical. Regardless of whether GME cuts are made in the context of workforce reform, preferentially supporting primary care and ambulatory care will have major policy impact.

To develop enthusiasm for restructuring health care, it is essential to understand the perspectives of the other participants in this process, namely, government and managed care. It is important, too, to recognize that all providers—including family physicians—will be forced to make major changes so they can provide alternatives to the marketplace. We also need to remember that the forces responsible for making these changes—cost and access—will not end after this year's budget process, but will likely continue in each future year.

Finally, it is absolutely critical for all health care providers to work collaboratively—for our patients, for our role as providers, and for the academic enterprise. In Washington and in the states, no single group speaks for primary care, for physicians, or for health care providers. Although legislators are sympathetic to primary care (for legislators are themselves generalists), they are frustrated that the three primary care specialties (family medicine, general internal medicine, and general pediatrics) often have difficulty agreeing with each other. In reality, patients and managed care organizations care less about these turf issues than do the physicians. In such instances, the legislative process tends to ignore the interests of those groups that are disorganized or speak with disparate and self-interested voices. There are similar conflicts between hospitals and physicians, between physicians and nonphysician providers, and between specialists and generalists. If health care providers fail to work collabora-

tively and remain disorganized, not only will they be ignored in the legislative process, but they will also minimize their influence in the marketplace, where the role of physicians in the medical decisions of integrated delivery systems looms as the major issue facing the profession.

References

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