Editorial

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Healthcare Reform in the United States: Fact, Fiction and Drama

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Contrary to the period in 1993, when the United States (US) President Bill Clinton failed to gain any traction on his healthcare reform, the current President, Barack H Obama, has been able to embark on historic healthcare reform. This is because major stakeholders agree that US healthcare is in crisis and requires major reform. Businesses and consumer groups have joined the insurance industry, pharmaceutical industry, and physician groups in asking for this healthcare reform that would blunt the rapidly escalating costs and provide healthcare for all Americans. While the number of uninsured Americans increased from 39.8 million in 2001 to 46.3 million in 2008, the National Health Expenditure (NHE) grew from 7.2% of the gross domestic product (GDP) in 1970 to 16% in 2005 [1]. This growth is projected to climb further to 19.5% in 2016. To put these figures into perspective, the US is projected to spend almost *$13 trillion* on healthcare over the ten years from 2010 to 2019 if the current trend continues[2]. Add to that the number of bankruptcies filed in the US due to healthcare expenses. Himmelstein and colleagues have recently demonstrated that of all the bankruptcies filed in the US in 2007, 62.1% were due to medical reasons as opposed to 46.2% in 2001 and only 8% in 1981[3] .

Hence, there is no longer any debate about 'whether there is a problem' but rather 'what can be done to fix this problem'. How to fix it has been, and will continue to be, a highly contentious issue that will pitch Democrats against Republicans even after the passage of the pending legislation. Some of the key elements President Obama had identified as his basic objectives in healthcare legislation, that he is expected to sign into law by the end of 2009, include:

1. Providing universal coverage to all Americans and requiring employers to provide health insurance to their employees.

2. Barring insurance companies from providing policies that would exclude patients with 'pre-existing conditions' thereby ensuring uniform health insurance premiums for all Americans irrespective of their health status.

3. Providing a one-stop marketplace for national health insurance exchange to allow consumers to compare and shop for different insurance plans.

4. Promoting the use of electronic medical records and the practice of evidence-based medicine.

5. Introducing a government-run health insurance option providing low cost, affordable health insurance that would directly compete with the private insurance industry.

This last provision, often called the 'Public Option', has been regarded by its opponents as an indication of how the federal government would grab political power and control the lives of all Americans. Some have gone as far as to say that the Administration is trying to introduce a 'socialist system' and set up 'death panels' to decide the fate of terminally ill Americans.

The raging debate in both Houses of Congress (House of Representatives and US Senate), since the introduction of the legislation early this year, has been highly partisan and, at times, acrimonious. The primary debate will continue to target accessibility and the 'Public Option' on one hand and affordability and deficit reduction on the other. Additionally, fundamental ideological issues of the rights of women to their health (*read* right for abortion) and accusations of 'socialist medicine' (*read* demand for free market healthcare with little or no government oversight) will continue to fuel this debate well after the legislation has been enacted into law. At the time of writing it is clear that President Obama's deadline of this year will not be met.

On 7th November 2009, President Obama won a major battle in this war when the House of Representatives passed the 'Affordable Healthcare for America Act'. The vote was 220-215 and essentially along party lines with the Democrats and only one Republican voting for this legislation. According to Representative John Dingle, the 83-year-old Michigan lawmaker who had introduced national health insurance in every congress since 1955, this 1990-page bill provides coverage for '96% of Americans and offers everyone, regardless of health

or income, the peace of mind that comes from knowing that they will have access to affordable healthcare when they need it'. However, in the run-up to the final vote, conservatives from both political parties joined hands to impose tough restrictions on abortion coverage that will continue to be a divisive issue throughout the legislative process [4] .

President Obama won the second major victory on 21st November 2009 when the Democrats (with the help of two independents) in the US Senate pushed the legislation past a key hurdle, despite vocal Republican opposition, with 60-39 votes. Sixty votes are needed in the US Senate to prevent 'filibuster' or an indefinite discussion on any bill [5] . With this vote the bill will now be debated in the Senate. Table 1 highlights some of the important features of the two bills:

Table 1: Important features of the Senate Bill and House Bill.

	Senate Bill	House Bill
Cost*	$848 billion	$1.02 trillion
Projected deficit savings*	$127 billion	$104 billion
New patients*	31 million	36 million
Protection against generic drugs**	12 years	12 years
Government sponsored program	New plan to compete with private plans; government to negotiate payment rates.	New public plan through insurance exchanges; government to negotiate payment rates.
Projected reduction in Medicare growth***	$400 billion	$400 billion
How is it paid for?	Fees on insurance companies, pharmaceutical and medical devices industries. A new payroll tax and 5% tax on elective cosmetic surgery.	$460 billion over the next decade from income tax on individuals making over $500,000 and couples making over $1 million per year.

* These are the estimates for the 10-year-period (2009-2019) from the Congressional Budget Office [6] .
** Both bills would protect biological drugs (made from living organisms rather than chemical compounds) from competition from generic drugs.
*** The reduction in Medicare spending is non-binding and future Congress can restore these cuts.

In this national debate, two well-known medical centres in the US, the Mayo Clinic of Minnesota and the Cleveland Clinic in Ohio, have frequently been cited as examples that could perhaps be emulated to deliver quality care in an efficient and cost-effective fashion. Both centres practise a 'medical home' concept based on a coordinated team approach that was introduced by the American Academy of Paediatrics in 1967. This has been further refined into the 'patient-centred medical home' by the American College of Physicians (ACP), American Academy of Family Physicians, and the American Academy of Paediatrics in 2007. This concept is exceedingly important for the management of chronic illnesses because the cost associated with unmanaged chronic conditions is astronomically high. It is estimated that 45% of the US population has a chronic medical condition. Amongst Medicare recipients aged 65 and above, 83% have at least one chronic health problem and almost 25% have at least five co-morbidities. Whereas the current system rewards acute care, it generally does not reimburse preventative care, chronic care management or active integrated inter-specialty management [7]. A medical home provides expanded primary care that is personalized, focuses on prevention, actively involves patients in making decisions about their care and helps coordinates all of their care.

One of the deficiencies of the proposed reform is the absence of any tort reform. For physicians in the US the threat of a malpractice lawsuit is real. Without legislative relief, 'defensive medicine' will take a significant chunk out of healthcare dollars. Estimates suggest that savings accrued from such legislation could account for 20-25% of the NHE and may be prudently used to reduce the healthcare costs. President Obama's outright rejection to consider tort reform in his address to the American Medical Association in June is very unfortunate and runs counter to his passionate plea to help reduce medical waste. Some of the important discussions that will take place relate to the need to revamp the physician reimbursement schedules and empower the Medicare Payment Advisory Commission to enhance primary care reimbursement, establish incentives to implement health information technology (including electronic medical records), and mandate the use of evidence based medicine and established protocols to stem the tide of escalating costs with 'pay for performance' and other quality measurements [8].

Healthcare reform must also address the physician shortage issue. Several studies, including those from the Institute of Medicine and the American Association of Medical Colleges (AAMC), have indicated a growing physician shortage particularly in Primary Care. In order to address this rising tide of physician shortages the Balanced Budget Act of 1996, that froze the number of reimbursable training positions at the 1996 level, needs to be revisited. As a preliminary target ACP and AAMC have recommended that the availability of Medicare-funded training positions in adult primary care specialties be increased by 3000 each year for the next 15 years [9-11].

From here on I suspect a bruising legislative debate (and drama) will continue with passion and, undoubtedly, some acrimony. Since mid-term elections are coming up in 2010, both the parties are jockeying their position as best as they can. To end the 'filibuster' the Democrats will need, yet again, 60 votes to pass the bill in the Senate. However that is not guaranteed at

this time since many Democratic senators continue to have concerns and Republicans have made it clear that they will do whatever they can to derail this initiative. Hence further deliberation, particularly in the Senate, will entail significant manoeuvring and arm-twisting, passionate appealing, horse-trading, and perhaps additional funding for select senators to achieve 60 votes. However, in the end there will be a bill from the Senate, perhaps in mid to late January 2010. Subsequently, a conference committee will hammer out the differences in the two bills that can be presented to both houses for final passage and submitted to the President for signature. I believe the President will have the bill on his desk for signature at the end of January or early February 2010.

COMPETING INTERESTS
None Declared

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