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10 Things I Hate About Health-Care Reform

One Doctor's Orders for How To Really Fix Our System

By Arthur M. Feldman
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As a cardiologist and the administrator of a large practice that includes general internists and specialists, I spend much of my time trying to figure out how to provide care for a growing number of uninsured or underinsured patients. I also have to battle billion-dollar private insurance companies that don't adequately cover patients with preexisting illnesses and often deny coverage for necessary treatments.

On a basic level, I'm with the president: Our health-care system needs to be changed so that all of my patients, and all citizens, have access to the care they need. But I don't agree with how he wants to fix things. Most of my colleagues and I strongly oppose the health-care reform bills that Congress will take up again this week. The proposals leave enormous gaps unfilled.

Before President Obama addresses a joint session of Congress on Wednesday, I hope he will consider these 10 major reasons why I -- and doctors like me -- worry that the legislation on the table will leave us worse off.

1. *Private insurance companies escape real regulation.*

This is what makes my colleagues and me so cynical about the reform proposals. Every physician has insurance company horror stories: patients who went untreated because their carriers wouldn't pay, endless hours on the phone to get administrators' approval for necessary tests and mountains of paperwork to collect reimbursements. It will be hard for doctors to buy into health-care reform if insurance companies get a free pass.

2. *We urgently need tort reform, but it's nowhere to be seen.*

Malpractice costs rise each year, as do the number of frivolous lawsuits. Our practice has seen a 10 percent increase in malpractice expenses this year. Sure, doctors make mistakes, and patients deserve fair compensation for their injuries and lost wages, but in this area of the law, physicians and hospitals are too often at the mercy of capricious juries.

When the president brought up the "fear of lawsuits" in his address to the American Medical Association in June, he got a huge response from the crowd. That's because practically every doctor has a story about a jury that awarded huge damages to a plaintiff despite the absence of wrongdoing by the physician. The best from our practice group is the physician who was sued -- even though he was out of town during the patient's entire hospitalization. Without fixing these spiraling insurance costs and the legal environment that allows large payments in unjust suits, physicians will continue to practice expensive "defensive" medicine or simply leave states that do not enact tort reform.

3. *"Prevention" won't magically make costs go down.*

Obama has called for disease prevention on a national scale, but that won't be a cure-all. Louise Russell,, a researcher at Rutgers University, analyzed hundreds of studies on prevention and medical costs and found that, in general, prevention adds to costs instead of reducing them. That's because it often means medication for hypertension and elevated cholesterol, and screening and early treatment for cancer. Unless Congress outlaws McDonald's, cigarettes, alcohol and idleness and cleans up the environment, no amount of "prevention" will put a

dent in the cost of keeping Americans healthy.

4. *Reform efforts don't address our critical shortage of health-care workers.*

Many people believe that the fix for our physician deficit is simple: expand class sizes at existing medical schools and create new ones. Sorry, it's not that easy. There is a cap on the number of federally funded training positions for newly minted M.D.s. It hasn't changed since 1996. If the number of graduates of U.S. medical schools increases but the number of post-graduate training positions remains the same, we won't have fixed the problem -- we'll have created a different one. Training programs will simply take more U.S. graduates and fewer foreign ones, and the total number of physicians trained each year will remain the same -- too low. And foreign medical school graduates tend to practice in rural and underserved urban areas, the very places that need the most help.

5. *We need more primary-care physicians -- but we also need specialists.*

Everyone is worried about the dwindling ranks of primary-care physicians. But we need more specialists, too. There are impending shortages in fields such as oncology, cardiology, general surgery and gastroenterology. An article in the American Heart Association's journal Circulation noted that by 2020 there won't be enough cardiothoracic surgeons to treat the growing number of American seniors. Surgery, the journal of the Society of University Surgeons, reported an expected shortage of 1,300 general surgeons in the United States by 2010. Few Americans will tolerate not having access to a specialist in an emergency or having care rationed because of a limited number of skilled physicians.

6. *We have to streamline drug development and shake up the Food and Drug Administration.*

Creating and producing new drug therapies in the United States is a nightmare. Regulatory hurdles, disorganization and a lack of leadership at the FDA, as well as burdensome conflict-of-interest policies, have made the drug-approval process grindingly slow. At the same time, development costs are close to $1 billion per drug. Federal regulations are so convoluted that most clinical trials are now performed outside the country -- taking billions of dollars out of the U.S. economy and making it harder for American patients to be first in line for new treatments.

7. *We can't fund health-care reform by cutting payments to doctors.*

This isn't about one doctor looking out for his bottom line. It's about physicians being able to provide the accessibility and quality of care that their patients want. The Centers for Medicare and Medicaid Services has proposed increasing payments to primary-care physicians by approximately 6 percent while lowering payments for many specialists, including cardiologists and oncologists, by as much as 20 to 40 percent. These drastic recommendations were based on a questionable American Medical Association physician survey showing that expenses for cardiology and oncology practices dropped precipitously over the past five years -- a finding that defies logic. If these cuts are approved, the American College of Cardiology estimates that 40 percent of the cardiology practices in Florida will go bankrupt. We need to pay for performance, not automatically reduce fees for procedures that patients have come to expect.

8. *We can't forget about research.*

Every modern treatment for human disease is related in some way to research at U.S. academic medical centers -- much of it supported by the National Institutes of Health. These include new treatments for cancer, devices to prevent sudden cardiac death and medications that save the lives of patients having heart attacks.

However, decreased federal funding for research over the past six years has threatened to decimate a generation

of young scientists and the cures they could discover. While the stimulus package provided $10 billion for NIH-supported research, the allocation was for only two years. The health-care reform legislation provides no information about the level of research funding after 2011.

9. *Cutting reimbursements could shut some hospitals down.*

Proponents of the current reform legislation know that no one wants their local hospital to close. So the White House's initial call to pay for health-care reform through cuts of more than $200 billion in hospital reimbursements over the next decade was scary. Obama sought to reassure people in June, explaining that "if more Americans are insured, we can cut payments that help hospitals treat patients without health insurance." But there is no data to support this promise. It is unlikely that the homeless, the mentally ill, the substance abusers or the illegal immigrants who now receive their care in "safety net" hospitals will carry any form of health insurance. Grady Memorial Hospital, one of the premier public hospitals in the United States, which has cared for the underserved residents of Atlanta for more than a century, would probably have closed its doors had it not been for a $200 million gift from a local benefactor.

10. *We need to improve the quality of care.*

Obama has said that "if doctors have incentives to provide the best care instead of more care, we can help Americans avoid the unnecessary hospital stays, treatments and tests that drive up costs." This is an overly simplistic view of what is needed. Poor care clearly costs more money. However, as the Institute of Medicine has pointed out, poor quality of care can be divided into three types: underuse of care, misuse of care and overuse of care. While eliminating misuse and overuse will decrease the cost of care, correcting problems from underuse will actually increase costs.

I have a close view of the limitations of our current health-care system. Not just with my patients, who are often unable to afford the care they need, but also in the plight of a young colleague. He was diagnosed with an aggressive form of lung cancer and sought treatment at a nationally renowned Boston cancer center. Most people with lung cancer undergo expensive chemotherapy and radiation therapy, but even those aggressive measures have a limited effect on long-term survival. His physicians discovered that he had a type of cancer that might respond to a new drug in clinical testing, provided free by the pharmaceutical company sponsoring the research. Although the cost of his care is far less than that of traditional chemotherapy, his insurance company refused to pay for it because it is "experimental."

But he has been lucky. His friends and colleagues have helped support his treatment, and wherever possible his doctors have provided free care. His cancer has responded dramatically to the drug, he has suffered no side effects, and he is back at work full-time.

However, I don't want my patients to rely on luck. I want them to have insurance that will pay for their care, and I want to be able to offer new medications and the most sophisticated treatment. I want to be able to give preventive care as well as to monitor patients effectively if they develop diseases. I want to be able care for my patients in their homes, and I want to offer palliative care if it becomes necessary. I want them to be able to afford all this. In short, I want to see major reforms in health care -- I just don't want what is on the table.

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