Articles in Common Sense are submitted more than two months before they are actually printed, which raises the risk of writing about topics which will be dated or proven incorrect by the time of printing. It is currently early November, and all the talk is about the launch of healthcare.gov, or the lack thereof. Let me start by stressing that I am non-partisan and independent – I have voted for Democrats and Republicans and usually find myself voting for the candidate with whom I have the fewest disagreements; kind of a lesser-of-two evils approach. As a medical professional, and one who spent many years in business before medical school, I am frequently asked my opinion on the Affordable Care Act, healthcare.gov, etc. It is a fair question, and one that should be encouraged since we are the people who should be taking the lead in developing health care policy in this country, rather than politicians in Washington whose ranks consist of only two senators and 17 congressmen who are physicians — in comparison to 211 lawyers in the legislature, which is fodder for future articles.

I could go out on a limb and make predictions on whether healthcare.gov will be fixed or whether Kathleen Sebelius will still have a job by the time this article gets published, but I won’t. Those questions are too difficult for me. Instead, I will offer a couple not-so-bold predictions that will likely be true in two months, and probably for much longer.

“Everything will be OK once I get health insurance.” This is a common mantra that I hear in our emergency department, and one that would be amusing if it weren’t so frightening. While having better access to primary care physicians and medications should help to control some pathology, I fear that many believe health insurance serves as a magic protective dome that will cover and guard them from getting ill. Many of the patients expecting miracles are those with chronic conditions: hypertension, HIV, diabetes, etc. Even with great medical care and perfect patient compliance, these types of illnesses don’t go away. The best one can hope for is some control of the condition while staving off some of its downstream complications. My not-so-bold prediction #1: health insurance won’t rid the country of disease.

Approximately ten years ago, when I was weighing the decision to apply to medical school, there was a flurry of conflicting reports coming out — half predicting a massive doctor shortage and half predicting a glut of physicians. Today the talk is decidedly one-sided, with recent reports stating there is a current shortage of 20,000 primary care physicians, with that figure exceeding 50,000 by 2025. Emergency physicians can expect to bear the brunt of this shortage, as more patients will use the emergency department as their primary care physician’s office. When universal health insurance was introduced in Massachusetts, patients saw immediate increases in waiting times to see their primary care physicians, and all 11 emergency departments assessed in a Harvard study found their patient volume increased. This led some hospitals, including Boston Medical Center, to sue the state over lack of sufficient reimbursement for the increased burden placed upon them. While some thought addressing the shortage of primary care physicians is included in the Affordable Care Act, including bonuses and improved reimbursements for preventative treatments, the gaps in salary and status among different types of doctors remain. My not-so-bold predictions #2 and #3: there will be a shortage of primary care doctors for a long time to come, and the emergency departments will become increasingly busy as a result.

“I want everything done.” Another common refrain heard in the emergency department. Often this comes after we deliver bad news to a loved one. Too often the patient is so sick that the best efforts of doctors and nurses serve only to delay the inevitable — at a huge cost. One cost is in the form of needless pain and suffering for the patient, which is why I am a strong advocate of palliative care services being available throughout the hospital, including in the emergency department. Another cost is in dollars-and-cents, and this is borne by everyone who pays taxes or is reliant on public services. When Medicare was first created, it was done without budget projections. That’s right, no one bothered to put together a simple spreadsheet to estimate the cost of something that would eventually consume billions of dollars each year. I fear that history has repeated itself, in that the focus has been on making sure people obtain health care, without discussion of how much health care our country can afford. Currently 25% of annual Medicare expenditures are spent on the 5% of Medicare patients who die that year. The more people who have insurance, the more people who will be empowered to say “I want everything done,” and the more the cost of health care will rise.

England employs a system to ration its health care dollars. The National Institute for Health and Care Excellence (NICE) was set up in 1999 with several tasks, one of which was to determine the cost-effectiveness of medical treatments. NICE uses a “quality-adjusted life year” (QALY) to objectively measure the value of treatments and procedures. QALY relies on calculations which are too detailed for this article, but essentially break down each month/year of life and assess a quantitative price to be paid for prolonging one’s life. If a proposed treatment is too expensive based on the QALY, then NICE will decline to fund it. While estimates vary, it appears that each year of life based on QALY is valued at approximately £20,000 to £30,000 ($32,000 to $48,000). I have never practiced in England, and cannot say how these figures are put into practice, but I cannot imagine the typical American health care consumer accepting QALY-type limits placed on the treatment of their mother/father/grandparent/children/selves, especially after being told that having health insurance would be a panacea. This leads to my not-so-bold prediction #4: we will need a real discussion about health care rationing, but our politicians will be too timid to do so in any real fashion.

While we’re talking about the Affordable Care Act and the doctor-to-lawyer ratio of 19-to-211 in our House and Senate, I would be remiss if I didn’t bring up tort reform and its omission from this landmark
legislation. Despite increasing the workload of doctors, no effort was made to remove the risk of litigation that accompanies each patient encounter. There are many reasons for this, not the least of which is the aforementioned doctor-lawyer composition of our lawmaking bodies. It is also evidence that no thought was given to managing health care costs, beyond ensuring people have insurance, despite the enormous costs that come with unnecessary testing and defensive medicine. One study found that defensive medicine contributed $280 billion in physician costs and more than $1 billion in hospital costs in 2008 in just one state (Massachusetts). While one would have hoped that any overhaul of our health care system would have included tort reform, my not-so-bold projection #5 is that addressing the litigious battlefield that doctors face everyday won’t be undertaken in the near future.

So those are my predictions for the next two months and beyond. They don’t offer any great clues as to how we will navigate the world of medicine once we’ve completed our residencies, nor are they breaking any new ground. Health insurance won’t be manna from heaven that cures disease, we will face an increasing doctor shortage with more patients visiting the ED, increasingly expensive and intricate health care will be demanded without consideration for how to pay for it, and doctors will continue to live and work under the constant threat of litigation. The news is now dominated by the Affordable Care Act, which would be a wonderful justification to discuss some of the difficult issues expressed in this article. My last not-so-bold prediction is that in two months, none of the real problems that our health care system faces will be addressed, much less solved.

Additional References
Massachusetts Medical Society, MMS Study Shows Patient Wait Times for Primary Care Still Long, 15 July 2013.

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