PETER DAZELEY

health care reform

WHAT IT MEANS TO A MEDICAL SCHOOL

The whole country is buzzing about health care reform—and with good reason. After months of debate, the Patient Protection and Affordable Care Act was signed into law on March 23 to decidedly mixed reviews. But what are the implications of the reform on today's medical students as they prepare to enter practice? Can reform counteract the shortage of primary-care physicians? Could it affect medical research? Case Western Reserve University School of Medicine professors George Kikano, MD; J.B. Silvers, PhD; and Kurt Stange, MD, PhD; and two current students weigh in on the topic.

medicus What are the biggest problems in the current health care system that today's medical students face as they prepare to move forward into residency and practice—and does the new act do anything to address these issues?

kurt stange Our current health care system is full of perverse financial incentives that can distort the focus of medical education. We don't have a health care system as much as we have a wealth-generating system for the health care sector.

As it stands now, we have an unsustainably expensive, fragmented, depersonalized, low-value health care system. The new act provides some helpful insurance reforms. On the surface, it does little to address the fundamental problems of fragmentation and lack of solidarity. However, by increasing access in a system whose trajectory already was unsustainable, the health care reform act creates some powerful incentives for multiple sectors to work together to emphasize the integrating, personalizing, prioritizing functions of primary care. Now the real work begins to develop systems focused on improving the health of the population.

jb silvers There are too many quality-control-type errors being made in the medical community today and part of the reason is the system is not organized to make sure they don't happen. The doctor is treated as an all-knowing person, which isn't realistic because no one always does the right thing. Errors occur because the system fails, not one individual.

Fortunately, the act has some provisions to change this kind of thinking. The first is a pay-for-performance provision that will hopefully get hospitals more organized. The second is the creation of two new centers. The Patient-Centered Outcomes Research Institute will conduct large-scale comparative-effectiveness research based on real-life data that will give doctors important feedback and help them make treatment decisions. And the Center for Medicare and Medicaid Innovation will look at novel ways to pay for chronic conditions. These two entities were a big part of the bill that didn't get any play in the media whatsoever.

m Why is there a shortage of primary-care physicians in our country, and did the reform act address this shortage?

george kikano It takes more than 10 years for a student to complete a medical education and establish a practice. The average student debt is $150,000—equivalent to a mortgage for most working families. There is large differential in compensation between procedurally oriented specialties and primary care, which accounts for the huge drop in the number of recent graduates going into primary care. There is a modest provision for additional pay for primary-care physicians, but this doesn't go far enough to make a real difference for students.

While the reform does call for coverage for an additional 32 million people by 2014, it does little to address access to much-needed medical care. The recent bill does not call for changes to any of the workforce distribution in terms of mix of primary-care physicians and subspecialty, or address any of the care to be provided in offices as opposed to the emergency room.

jbs In the 1960s, '70s and '80s, people were drawn to primary care as a way to do good. Not many of them can afford to do that anymore because of the huge gap between primary-care and specialty incomes coupled with large student debt.

The stop-gap terms in the act will help. Physicians in primary-care practices doing evaluation and management billing codes will get an increase in Medicaid primary-care rates to Medicare levels, plus a 10 percent bonus above normal Medicare reimbursement rates and another 10 percent extra if they practice in an underserved area. Because most insurance companies copy Medicare payment rates, this will have a leverage effect.

In the longer term, the codes for billing that drive net incomes for doctors will be re-evaluated so that surgical and interventional-medicine codes will be brought down and that money would be reallocated to primary-care codes. This will hopefully mean that the incentive for medical students to choose a relatively small set of extremely highly paid specialties will decrease and people will be more attracted to primary care. In the national residency match this year, primary care went up by 9 percent, which is encouraging because it had been going down for a long time.

m Will the act have an effect on medical research, and what further reform would you like to see to aid medical research?

ks We need to focus not just on molecules, but on how to generate new knowledge to advance the health of whole people and communities. The act's call for comparative-effectiveness research, if it becomes more broadly conceptualized, may help us to make good choices about what the most effective treatments are for different conditions. And hopefully that will help us prioritize how health care can be focused to get the most bang for our buck.

jbs Yes, the new, independent Patient-Centered Outcomes Research Institute will begin conducting comparative research and there will be hundreds of millions of dollars available for that.

The reform act also will help promote the expanded use of electronic medical records, which I think is as much a research tool as it is a patient-care tool. It will help us do the kind of things we used to attempt through registries, and it will allow us to do research in a community setting, as opposed to very tightly controlled, and therefore limited, clinical trials. So we'll be looking at larger populations of people, in a real setting, the way they actually behave. That makes it a much more robust kind of research.

gk At this point, most of the National Institutes of Health budget, outside of the Clinical and Translational Science Center, is directed to basic science research. There is little research funding that is earmarked for primary-care or public-health research. The newly created comparative-effectiveness research office has the potential to generate data that will result in lowering costs.

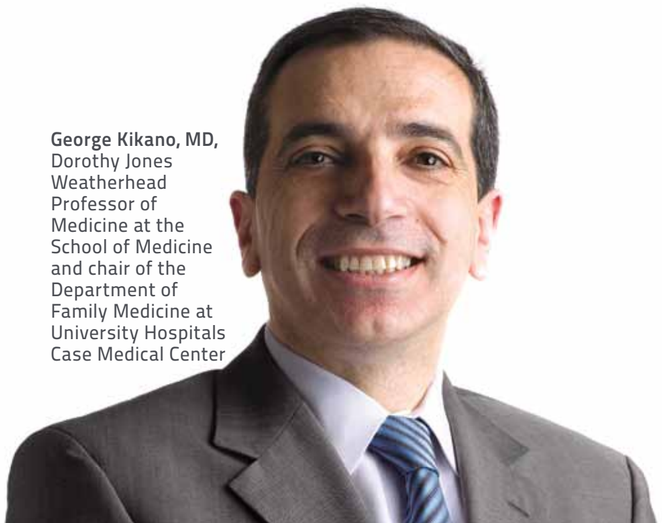
m Do you feel generally optimistic or pessimistic about whether this new act will improve our health care system and whether that system will undergo significant improvements in the near future?

gk I think it's a small, expensive step in the right direction, but it doesn't go as far as we need to go. We're spending a trillion dollars for little return. I would still like us to have major reform to address how care is delivered: timely access to medical care in the right setting, better coordination of care for chronic diseases, strong emphasis on prevention and wellness, reduced waste, improved quality and an end to the practice of defensive medicine.

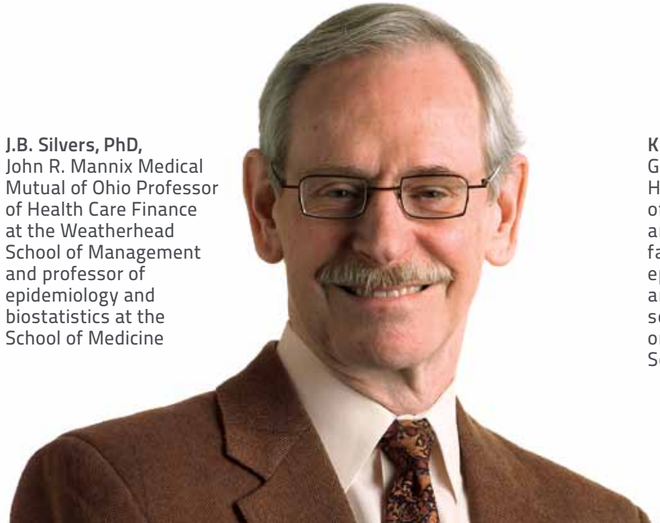
ks I think it's up to us to work together to create space for dialogue about the common good. Right now we don't have enough places for real dialogue about the difficult choices and tradeoffs involved in health care reform. We haven't been having true conversations; we've mostly had sound bites designed to elicit an immediate, visceral reaction that puts us in one of two camps. However, I think the medical school and its partners are in a great place to move beyond ideological debates to start to create space for considering and working toward the possibility that a bit of giving by all sectors can result in a larger good.

There will be much wailing and gnashing of teeth along the way, but it is up to us to take responsibility for fostering a shared vision and to develop sustainable systems focused on the larger societal good. I suspect there will be a difficult transition period, when things will seem to get worse before they get better. But I'm optimistic that change will happen.

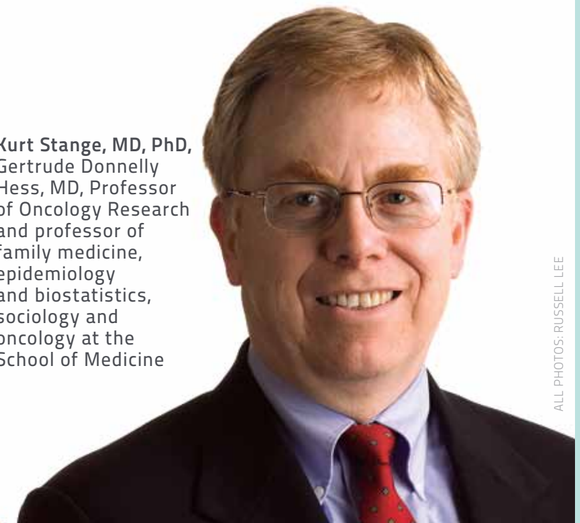
jbs I'm far less pessimistic—and I'm a gloomy economist by training! Including everyone under some form of coverage is the first step to changing the system. Better comparative research, electronic patient information and incentives are next. A system focus on quality is the third. And major reorganization of delivery is the final step in creating a real health care system. We are well on the way. Medical research will help us along by eliminating the need for some of our most expensive and poorest outcome approaches. I expect things will keep getting better.



George Kikano, MD, Dorothy Jones Weatherhead Professor of Medicine at the School of Medicine and chair of the Department of Family Medicine at University Hospitals Case Medical Center



J.B. Silvers, PhD, John R. Mannix Medical Mutual of Ohio Professor of Health Care Finance at the Weatherhead School of Management and professor of epidemiology and biostatistics at the School of Medicine



Kurt Stange, MD, PhD, Gertrude Donnelly Hess, MD, Professor of Oncology Research and professor of family medicine, epidemiology and biostatistics, sociology and oncology at the School of Medicine

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THE STUDENT PERSPECTIVE

TAMARA LEE

Tamara Lee is a second-year medical student at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

I'm hoping that at the very least, my patients will be able to afford health care! I believe this will improve the doctor-patient relationship because patients will be able to take the medications and obtain the therapy or procedures they need, and I won't have to waste as much administrative time, effort and money providing justifications to insurance companies. I also won't feel compelled to order unnecessary tests and procedures for fear of litigation, and I believe my medical decisions will be more directed and informed, based on conclusions of qualitative health outcomes research.

Right now, I am not sure what field I will pursue. I start my rotations next year and hope to find inspiration. I hope that as I advance in my career I can hold on to the same idealism that I have right now—that is, I want to go into a field that I am passionate about, not necessarily the field that will pay the best or see the least malpractice cases.

I sense optimism among my generation of medical students. Hopefully, we will be practicing in a better health care system—one in which we are doing everything we can to prevent, treat and cure disease.

TIM ANDERSON

Second-year Case Western Reserve School of Medicine student Tim Anderson is president of Case Western Reserve's chapter of Physicians for Human Rights and vice president of the university's chapter of the American Medical Student Association. He holds a master's degree in bioethics.

The health care system does impact how we choose our fields. The media often focus on how primary-care doctors are underpaid compared to specialists, and, while this is both true and a direct result of the current insurance system, what I have learned from my mentors at Case Western Reserve is that the biggest obstacle in primary care is the frequency burn out—often after five to 10 years of practice due to heavy work hours, paperwork and difficulty communicating with their patients. Recruitment of primary-care doctors is further complicated by low reimbursements and a lack of excitement at medical school for primary care due to the less advantageous lifestyle.

I have not chosen a specialty yet, but I'm leaning towards pediatrics or internal medicine because I value their continuity of patient care. As medical students, I think we generally have a fresh and optimistic outlook to health care reform. We are still separate enough from billing and paperwork to think about how to address health disparities and improve medical care through reform, and not just change payment methods.