Can Docs Bridge US Over the Cliff?

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I was surprised to wake up after Election Day to find that both my state and national representatives were now physicians (Ami Bera, MD, and Richard Pan, MD). California's two newly elected Congressional physicians (Dr. Bera and Raul Ruiz, MD) will now join 13 House physicians and three Senate physicians in the 113th Congress in January. Can these 18 docs in Congress help us avoid the fiscal cliff and get serious about addressing healthcare reform?

The recent Supreme Court decisions, Presidential reelection, and US Senate majority along with California's in-state supermajority now make healthcare reform a fact of life. It will proceed in an environment of overwhelming state and national budget deficits, a projected fiscal cliff with likely tax increases and spending cuts, a possible 58% total cut in cardiology reimbursement rates, and an evolving healthcare policy direction.

California was the first state to pass legislation implementing the regulated insurance exchanges under the Affordable Care Act, and next month our governor intends to call a special legislative session on healthcare reform.

Can we continue to advocate for maintaining our current health care funding while cutting other departments? We do realize that healthcare funding has increased from 5% gross domestic product (GDP) to 17.6% GDP over the past 50 years and could achieve 20% GDP in the next decade. Meanwhile, other countries survive on 6% to 12% GDP. The United States still maintains the highest hospital, ambulatory, pharmaceutical/medical goods, and public health/administration costs. Our average health expenditures per capita ($8233) are higher than any other Organization for Economic Cooperation and Development (OECD) country and 2.5 times higher than the average ($3265).[1] Cardiovascular care contributes to this by performing more coronary artery bypass graftings (CABGs) and percutaneous coronary interventions (PCIs) at higher costs than in any other OECD country. The seemingly draconian 58% cuts would take us back not to the Stone Age, but to the level of most modern Western societies.

There is no question that US medicine is excellent; the question is whether we can continue to afford it. Can the fiscal cliff crisis actually provide us an early opportunity to redesign the future of healthcare? Can we take advantage of the remarkable advances in novel diagnostic and therapeutic modalities, computer-assisted record and

management programs, mobile information and communication technology, and effective diagnostic, therapeutic, and preventive care programs to both improve healthcare and lower costs?

Physicians have the training and experience to tackle these areas and help redesign this future. The patient of the future will be imbedded with chips that contain the complete DNA, RNA, and metabolic profiles of the patient while monitoring acquired risk factors and alerting both patients and providers about changing conditions and new developments. However, this technology is not yet ready for prime time. For now we must build a bridge to this future. Our current fiscal crisis options include extending the Medicare eligibility age, reducing benefits to high-income earners, and promoting healthcare competition, prevention, and quality over quantity. However, extending Medicare age eligibility may be difficult for low-income laborers, making high-income earners ineligible may lower overall Medicare popularity, and promoting healthcare competition and quality over quantity may be difficult when patients and families demand all the latest high-cost procedures for loved ones.

Cardiology has often led the way in developing programs and tools to assist healthcare practitioners in delivering high-quality, cost-effective care. Our professional societies have developed comprehensive diagnostic and treatment guidelines to improve the quality of cardiovascular care. The multiple NCDR® registries provide extensive clinical databases on outcomes and appropriate care and have put quality on the map. Cardiology programs to improve inpatient and outpatient performance and reduce re-hospitalizations and overutilization also exist. These guidelines, datasets, and tools have been used to improve cardiovascular care and reduce costs. It is time to lead our fellow healthcare providers over this bridge to the future of improved care and reduced costs.

Fixing Medicare and Medicaid and surviving the fiscal cliff will not be easy, but we must all agree to do it. Our physicians on the Hill today are perhaps the best qualified legislators at the Capitol to begin building our Bridge to the Future of Medicine and Cardiovascular Care. We now have 18 votes we can count on. Hopefully by the time you read this we will be well past the cliff on our bridge to the future. ■

Reference

1. Health policies and data: OECD Health Data 2012. Organization for Economic Cooperation and Development Web site. http://www.oecd.org/health/healthpoliciesanddata/oecdhealthdata2012.htm. Accessed January 2, 2013.