Will Health Care Reform Remain Stymied By Ideology,

Or Will Progress Occur at the Local Level Because the Status Quo is Untenable?

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LESSONS ABOUT IDEOLOGY FROM POLITICAL SCIENCE

One of the enduring exercises in political science is a discussion of the relative merit of politicians who adhere to their principles, versus those who flip-flop.

"WHAT?" you say, "how can there be any merit in flip-flopping." Indeed, that epithet is a damaging label that politicians try to stick on opponents. But are politicians who flip-flop always undesirable, or does "ideological plasticity" mean they are willing to listen to differing opinions and are not immune to reason? Are they necessarily worse than ideologues who advance their often extreme points of view against all counter-arguments? Flip-floppers include such Presidents as Abraham Lincoln, Woodrow Wilson, George H. W. Bush, and Bill Clinton, all of whom altered their stances on crucial issues (respectively: emancipation of slaves, declaration of war, new taxes, and new taxes). They did so not only in response to what they saw as the national interest, but also with an eagle eye for changing political reality and public opinion.

We live in a participatory democracy. Would it be better to have politicians who are insensitive to public opinion and proceed according to their own extreme inclinations? Sometimes that is what is needed to display true leadership. But at other times, "Damn the torpedoes, full speed ahead" can be a disastrous way to govern, even if it is an inspiring battle cry. We have experienced the consequences of that approach from both sides of the political aisle, with the invasion of Iraq by the administration of George W. Bush, and the expansion of the Vietnam War by the administration of Lyndon Johnson. Both wars would have ended years earlier if public opinion held sway.

HEALTH CARE REFORM AND THE SUPREME COURT

I bring these considerations to this medical journal because they are directly relevant to the current challenge to the individual mandate in the Patient Protection and Affordable Care Act which is now before the Supreme Court. The outcome is uncertain, because though there is no doubt that the imperative to buy health insurance by 2014 or pay a fine is a case of the Federal government telling individual citizens what to do (or what not to do), there are countless examples of its doing so already for the sake of the public good.

Though health care reform is already under way at the grassroots level (more about that below), the Affordable Care Act is an attempt to accelerate and direct that process by Congressional action. It was surely quite an accomplishment to get this legislation passed, since there seems a greater tendency toward inflexible adherence to principle in Congress than many of us can remember seeing before in our elected representatives. But having reached the Supreme Court, a key part of the legislation will be decided not by ideologues who are our elected representatives, but by ideologues who are not elected. The Justices of the Supreme Court are appointed for life in order to protect them from external political pressures, but they are hardly immune to their own ideologies and internal prejudices. Historically, most Justices have such hardened attitudes that their votes have been predictable. The current Court is a relatively typical example of ideological bias, with only one Justice, Anthony Kennedy, whose vote is usually pivotal. The presence of one "swing vote" means there is often only one Justice whose mind does not seem to be made up in advance, and who can hopefully be persuaded by argument.

I find the concept of a single "swing voter" depressing. Would it be better if more, or even all nine, Justices were persuadable "swing voters?" In the history of the Court over the past century, there have been relatively few Justices whose attitudes have evolved or at least been unpredictable during their terms in office. Justice Byron White, though appointed by John F. Kennedy and expected to be a reliably liberal voice, took a fact-based approach to his decisions (he wrote almost 1,000 opinions) and dissented from both the Miranda decision and *Roe v. Wade*. Justice Harry Blackmun, though appointed by Richard Nixon on the recommendation of Blackmun's friend, conservative Chief Justice Warren Burger, evolved into a generally liberal voice

who voted with Berger only 30% of the time and wrote the Court's opinion in *Roe v. Wade*. Anthony Kennedy, the current "swinger," was appointed by Ronald Reagan and was expected to be reliably conservative. Interestingly, Sandra Day O'Connor, Kennedy's predecessor as the swing vote, was also a Reagan appointee.

WHAT NEXT?

Most observers consider it unlikely that the Supreme Court will strike down the entire Health Care reform law, as no appeals court has gone that far. The court could strike down only the insurance mandate, leaving in place such provisions as a Medicaid expansion expected to help about 16 million uninsured people, the creation of new state health insurance markets, Medicare cuts, and a plethora of regulations. But without the insurance requirement, insurers would be deprived of a large pool of insured and presumably healthy people over which to spread the costs of caring for the ill.

Regardless of the logistical complications for health care imposed by this challenge, it is widely recognized that our current health care system is unsustainably costly, inefficient, filled with perverse incentives, and hard to access. Further, against all the evidence that competition does not lower costs in health care, the private sector and profit motives remain a dominant force in our health care system.

The current Congress is so riven by ideological differences that it couldn't even forge an agreement last August to raise the debt ceiling, or—more recently—to reduce federal spending by constructing a combination of tax increases and spending reductions. If the current health care legislation is overturned, it is unlikely that Congress will be able to pass meaningful health reform.

Health care straddles an ideological divide. There are those who wish to preserve the dominant role of the private sector, though insurance companies (including so-called "non-profits") add 16-20% in administrative costs which could instead be used to expand coverage.[1,2] And there are those whose priority is to expand coverage, but they pay for it in great part by reducing payments to providers.

THE FUTURE

Many solutions have been proposed to maintain the current multiple-payer system while reducing the overall cost of health care; some of the concepts overlap or share characteristics, if not labels. They include bundling of payments and use of global fees to reduce the perverse incentives of fee-for-service that encourage overutilization; establishment of medical homes to enhance coordination of care and reduce Emergency Department visits and hospital admissions; vertical integration of care with an employment model for physicians; and introduction of Accountable Care Organizations to transfer risk to providers.

And though single payer "Medicare for all" is a proposal that is increasingly popular among those who work in health care because they are comfortable with Medicare's mechanisms, and it would surely please the public, it would be exorbitantly expensive if it were simply expanded to the entire population while preserving fee-for-service reimbursement.

Far more efficient is a vertically integrated, employment model health care system. Kaiser Permanente is the largest non-profit health system in the country, with almost nine million subscribers, and has proven its effectiveness for decades.

Meanwhile at the community level, vertical integration is taking place even without attaching that label. Providers on the front lines cannot sit idly by without preparing for the inevitable changes that will be required in the health care system. Hospitals and physicians are combining not only to align incentives and affiliate contractually, but increasingly to enter into outright employment arrangements. Insurance companies and providers are negotiating with the understanding that the status quo is going, going, gone.

And, of course, the consumer/patient has—often for the first time—become sensitized to the cost of health care by rising deductibles and co-pays, and the risk of losing coverage outright. Further, employers are not only putting employees at risk for more of their health care expenses, but are rewarding or penalizing them for good or bad health habits such as weight loss or smoking. All of these approaches merit thoughtful analysis and discussion, and this column can only introduce the subject and point out some of the complexities.

Though the word "rationing" has always been anathema in the U.S., we have always had rationing of health care because we don't provide universal coverage. As a result, those who cannot pay often ration themselves by delaying care.

These are hard realities in many parts of America, but regardless, we as professionals must put our patients first. Our first priority should always be to preserve the quality and availability of the care we provide,

while acknowledging that the system can no longer pay for everything. We can only hope that the health care debate will focus on how to create the best care for the most affordable price, rather than being a referendum on the role of government in society.

Finally, we are fortunate and can be proud to live and work in Lancaster where Lancaster General Hospital provides service to all, and physicians have formed PALCO (Project Access Lancaster County), a physician-led volunteer community effort that provides free healthcare to low income uninsured Lancaster County residents who do not qualify for Medicaid or other insurance, and whose annual income is less than 200% of the federal poverty level.

As a coordinated system of charity care that provides the full continuum of medical care to eligible patients, it works not only because of volunteerism by physicians who see patients for free, but also partnership among hospitals, pharmacists, other healthcare providers, and community organizations who all participate in this program to benefit the community.

IN THIS ISSUE

We continue our exploration of the benefits of Integrative Medicine with the second article by Dr. Jennifer Kegel. In this personal account of her own experiences, she and Dr. Daleela Dodge further develop the concepts of Integrative medicine, review the studies that have demonstrated tangible benefits, especially in breast cancer patients, and describe the clinical experiences that led them to incorporate these practices into their clinical care.

Next, Dr. Susan Bator provides a highly informative overview of the benefits, risks, and current practices of blood transfusion; Yuri Anna Lee and Lisa Ruth Sahd, CCRN, offer a fascinating description of the Amish use of Burdock leaves as a topical healing agent; Charles Romberger, MD describes the dramatic changes that are beginning to be wrought by digital pathology; and Alan Peterson MD's article strongly advocates mandatory flu vaccination for all health care workers. Chris O'Connor, Esq. provides a commentary from the office of General Counsel. Also from the office of the General Counsel, Margaret Costella, Esq. provides an overview of the new standard orders for POLST—Pennsylvania Orders for Life Sustaining Treatment.

The issue is chock-full of interesting material, so get started reading without delay!

And finally, Happy Holidays to one and all.

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