



2009 Advocacy Briefing Book



NMA's Position on Key Health Policy Issues

Costs

Prioritizing Prevention

An increased emphasis on preventive care¹ would significantly alter the health system's current cost equation. Currently, about 75 cents of every healthcare dollar² goes to chronic disease management, most of which are either preventable or treatable. Not only is treating disease after it has progressed more expensive and more time intensive, it also compromises a patient's quality of life.

Save Money Where We Can

The President has been very clear that health care reform should not "break the bank". In other words, he is committed to signing health care reform legislation *only if* the final package is deficit-neutral. To that end, it is critical that the health care system reduces spending by reducing waste due to fraud, abuse, medical errors, duplication, and over-utilization of services. Further, overpaying for services that do not lead to increased value or improved outcomes, such as the overpayment from the Federal government to Medicare Advantage plans, should be promptly rectified as appropriate.

Invest Where We Should

In addition to prevention, our nation will need to make investments in healthcare reform that would appear at odds with the economic forecasting models deployed by the Congressional Budget Office (CBO). The NMA holds that investments in the nation's healthcare workforce (see below), realigning economic incentives³, and an increased focus on improving health outcomes are all examples of structural changes that will enable our healthcare system to perform more efficiently. The 'reserve fund' proposed in the FY 2010 budget is a great first step.

Focus on improving health outcomes

Americans should be better off after they exit the healthcare system than they were on entry. This should be true of every healthcare encounter. Unfortunately, even after spending more money⁴ than any other nation on Earth, our competitors in the industrialized world boast better outcomes across several indicators⁵. We agree with the President - more care does not always

¹ Thorpe, Ken. "PFCED Executive Director Ken Thorpe Testifies Before House Subcommittee." <http://www.fightchronicdisease.org/news/pfcd/pr021408.cfm>. Feb. 14, 2008. Partnership to Fight Chronic Disease. 13 Jul 2009 <<http://www.fightchronicdisease.org/news/pfcd/pr021408.cfm>>.

² Ibid

³ Cannon, Michael F. and Tanner, Michael D. . *Healthy Competition: What's Holding Back Healthcare and How to Free It*. National Book Network, November 2007. Print.

⁴ "Health Spending in Most OECD Countries Rises, with the U.S. far Outstripping all Others." *OECD*. 2004. Organisation for Economic Co-Operation and Development. 13 Jul 2009 <http://www.oecd.org/document/12/0,3343,en_2649_201185_31938380_1_1_1_1,00.html>.

⁵ Ibid



equal better care. The ultimate goal of our reform efforts should be to improve health outcomes so that we can improve the health status of every American. This requires a renewed effort to improve quality as we reduce costs, and a renewed zeal to eliminate disparities and inequities in the system (see below).

Coverage

Cover Everyone

In 2004, the Institute of Medicine (IOM)⁶ concluded:

- Health care coverage should be universal.
- Health care coverage should be continuous.
- Health care coverage should be affordable to individuals and families.
- The health insurance strategy should be affordable and sustainable for society.
- Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

The NMA agrees with the IOM.

Many of our competitors in the industrialized world are able to *provide health care for their entire populations, for less money* than we spend to exclude one out of every six Americans. In other words – we could do much better without spending any new money. While universal coverage would not guarantee increased access or improved outcomes, it would reduce the inordinate amount of money we waste on emergency room (ER)⁷ care, which is often the first and last resort of the uninsured. It is well established that ER care is inefficient and ineffective⁸ for fundamental reasons, including - it is more expensive than if the patient had been treated earlier when the condition was less complex, and the cost of ER care is passed on to the rest of society since the patients themselves are often unable to afford it. Notably, unpaid medical bills are the nation's leading cause of personal bankruptcies.

More importantly, NMA supports health care coverage for all because uninsured populations access medical and dental services less often than their insured counterparts, and are less likely to receive routine preventive care.⁹

⁶ "Consequences of Uninsurance." *Institute of Medicine of the National Academies*. 6/12/2009. Institute of Medicine of the National Academies. 13 Jul 2009 <<http://www.iom.edu/?ID=4660>>.

⁷ "The Future of Emergency Care: Key Findings and Recommendations." *Institute of Medicine* 2006 Web. 13 Jul 2009. <<http://www.iom.edu/Object.File/Master/35/040/Emergency%20Care%20Findings%20and%20Recs.pdf>>.

⁸ Ibid

⁹ Newacheck et al., 1998b; McCormick et al., 2001; IOM, 2002b



Finally, universal coverage is crucial to health care reform because disparities in health outcomes are exacerbated when the most vulnerable populations have restricted access to care. We cannot improve health outcomes if we don't fix coverage.

Public options should exist

NMA would remind the U.S. Congress and the American people that the 'public option' [Medicare, Medicaid, Children's Health Insurance Program (CHIP), Federal Employee Health Benefit Program (FEHBP)] already exists. Notably (in the case of Medicare and CHIP for instance) the public option is considered rather popular. These public programs constitute the healthcare safety net, and, though imperfect, most lawmakers would fight to the death to keep them viable. A new public option, as part of a health insurance exchange (HIE), would be a welcome addition to the healthcare marketplace. We concede that this option should be very carefully designed, in order to avoid the reimbursement problems that currently plague Medicare and Medicaid.

Protect Consumer Choices

Many Americans are understandably fearful that sweeping health care reforms will compromise doctor-patient relationships, or further distort insurance markets. These negative developments, they argue, will further weaken the free market's ability¹⁰ to weed out the non-performers in the health care sector. The NMA underscores the need to maintain the integrity of the doctor-patient relationship. We maintain, however, that if consumers decide that a given public option, say FEHBP, delivers higher quality care than Private Plan X, then they should be free to 'vote with their pocketbooks'. Too many are denied this opportunity in the current marketplace, hence the pressing need for reform.

Preserve the Safety Net

As noted in earlier sections, the healthcare safety net should remain in place during the reform process, and for a reasonable period thereafter. Current health care reform negotiations making their way through Congress include reducing the Disproportionate Share (DSH) payments hospitals receive for providing uncompensated care. These subsidies are crucial to the survival of public hospitals, and we oppose their elimination until we can demonstrate they are no longer needed.

The current economic downturn has resulted in a growing number of uninsured and a decrease in Medicaid budgets. The dwindling number of primary care providers¹¹ compounds the crisis.

¹⁰ Cannon, Michael F. and Tanner, Michael D. . *Healthy Competition: What's Holding Back Healthcare and How to Free It*. National Book Network, November 2007. Print.

¹¹Herring, Lori and An, Jane and Salganicoff, Alina . "Healthcare Safety Net." *KaiserEDU.org*. 2009. Kaiser Family Foundation. . 2 Jul 2009 <http://www.kaiseredu.org/topics_im.asp?id=965&imID=1&parentID=71>.



Maintaining the integrity of the health care safety net is especially vital in rural areas or inner city neighborhoods where there are fewer health care providers. Thus, the health care safety net plays a life-saving role in catching individuals that fall through the cracks, particularly low-income individuals.¹²

Quality

Train more primary care providers

Not only is the supply dwindling, but there is a corresponding explosion in demand for primary care physicians. With a growing number of Americans living longer and therefore more susceptible to multiple co-morbidities, increasing the number of geriatricians¹³, for example, has never been more urgent. Simply put, medical school graduates are increasingly choosing to go into more lucrative specialties at the expense of primary care. Economic pressures¹⁴ tend to drive many of these residency and specialization choices. Some of these primary care slots are being filled by international medical graduates (IMGs). In addition to incenting medical school graduates to choose primary care, the nation should implement policies that would provide cultural competency training for international medical graduates practicing in the U.S.¹⁵

In addition to the relative dearth of primary care physicians among the general population, declining reimbursements are contributing to the growing phenomenon of doctors refusing to see Medicare patients. Unless we solve the vexing problem of the Sustainable Growth Rate (SGR)¹⁶, this access problem will continue. The recent report¹⁷ by the Medicare trustees regarding the steady erosion of the Trust Fund should punctuate that alarm. Health care reform will fail if we do not address these short and long term challenges.

The aforementioned is likely to have a disproportionate impact on vulnerable populations. In order to ensure that more underrepresented minorities are part of the next generation of physicians, we should encourage policies that yield individual and

¹² Herring, Lori and An, Jane and Salganicoff, Alina . "Healthcare Safety Net." *KaiserEDU.org*. 2009. Kaiser Family Foundation. . 2 Jul 2009 <http://www.kaiseredu.org/topics_im.asp?id=965&imID=1&parentID=71>.

¹³ Fuchs, Elissa . "IOM Report Finds Health Care Workforce Unprepared for Elderly." *Association of American Medical Colleges*. AAMC. 13 Jul 2009 <<http://www.aamc.org/newsroom/reporter/june08/aging.htm>>.

¹⁴ Ibid

¹⁵ Fiscella, Kevin and Frankel, Richard . "Overcoming Cultural Barriers: International Medical Graduates in the United States." *Journal of American Medical Association* 283:1751-2000 Web. 7 Jul 2009. <<http://jama.ama-assn.org/cgi/content/full/283/13/1751>>.

¹⁶ "Review of CMS's preliminary estimate of the physician update for 2010." *MedPAC*. June 2009. MedPAC. 13 Jul 2009 <www.medpac.gov/chapters/Jun09_AppA.pdf>.

¹⁷ Ibid



institutional impact¹⁸. High school pipeline programs are not enough; the pipeline programs should begin in elementary school. Academic enrichment, mentorship, research apprenticeships, and academic partnerships, are all helpful.¹⁹ Long-term partnerships such as the one that exists between Baylor College of Medicine and Houston's public schools can serve as a national model²⁰.

Strengthen Public Health

Having an efficient national and local public health infrastructure enhances our nation's ability to respond to emergencies and threats²¹, from terrorist attacks to natural disasters. Most recently, swine flu has demonstrated the need for a national commitment to a sturdy public health infrastructure. We remind the nation that on a day to day basis America's public health system: administers vaccines; ensures the safety of our food and water; investigates disease outbreaks; educates the public about issues ranging from obesity to smoking cessation; and supports the work of individual clinicians. As inexorably as night follows day, a crumbling public health apparatus will compromise not only our health status, but our national security as well.

Stakeholder Input

The White House Office of Health Reform has gone to great lengths to ensure that all relevant stakeholders are at the table as we proceed toward health care reform.

*Employers, for example, are *sine qua non* to the discussion. Given that more than half of all insured Americans get their health care coverage as an employment benefit, American businesses, large and small, have made their presence felt in this debate. So much so, that the President has taken to citing successful workplace 'wellness' programs²² that have been successful in improving health and reducing costs.

*America's schools are ground zero for fighting the obesity epidemic. School based programs for good nutrition (and increased physical activity) will be pivotal to

¹⁸ Murray-Garcia, Joan and Garcia, Jorge. "From Enrichment to Equity: Comments on Diversifying the K-12 Medical School Pipeline." *Journal of the National Medical Association* Vol 942002 721-731. Web.10 Jul 2009. <<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2594269>>.

¹⁹ Murray-Garcia, Joan and Garcia, Jorge. "From Enrichment to Equity: Comments on Diversifying the K-12 Medical School Pipeline." *Journal of the National Medical Association* Vol 942002 721-731. Web.10 Jul 2009. <<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2594269>>.

²⁰ Murray-Garcia, Joan and Garcia, Jorge. "From Enrichment to Equity: Comments on Diversifying the K-12 Medical School Pipeline." *Journal of the National Medical Association* Vol 942002 721-731. Web.10 Jul 2009. <<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2594269>>.

²¹ Miller, Becca and Hsiao, Amber and Ranji, Usha and Salganicoff, Alina . "The State of Public Health Preparedness." *KaiserEDU.org*. 2008. Kaiser Family Foundation. . 2 Jul 2009 <http://www.kaiseredu.org/topics_im.asp?id=619&imID=1&parentID=61>.

²² "Fact Sheet - Innovative Workplace Practices: A Discussion with President Obama." *Office of the Press Secretary*. May 12, 2009 . The White House. 13 Jul 2009 <http://www.whitehouse.gov/the_press_office/Fact-Sheet-Innovative-Workplace-Practices-A-Discussion-With-President-Obama/>.



preventing diabetes and all other complications related to obesity. The same could be said for smoking. Preventing youngsters from trying that first cigarette is one key goal of the law the President recently signed that now directs the FDA to regulate tobacco. The NMA supports all such efforts. No health care reform proposals would be complete without them.

*Community-based organizations (CBOs) provide an uncelebrated yet crucial role in health education and awareness. Care coordination efforts would be greatly enhanced if CBOs are considered an integral part of reforming health care delivery. There is growing evidence that patient compliance, for example, can benefit from the help of teams that CBOs can help assemble. The NMA partners with some of these organizations, and recognizes their value in disease prevention, health promotion, and primary care.

Cultural Competency

The Office of Minority Health (OMH) defines cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."

Cultural competency training of health professionals is a necessary tool for addressing racial and ethnic health disparities.²³ This is a sentinel advocacy issue for the NMA in the coming year. Health care reform should ensure the implementation of cultural competency curricula and training programs for all health care professionals. OMH can (and should) take the lead in making sure these programs proliferate across the states. There are lessons (from the successes and challenges) the nation can learn from states like New Jersey that were 'early adopters' in requiring cultural competency training as a prerequisite for licensure.

Care Coordination

It is critically important to implement a higher degree of care coordination in order to use scarce medical resources efficiently, especially in light of the rise in the prevalence of chronic medical conditions. Currently, 45 percent of the population has at least one chronic medical condition²⁴ and as the nation's baby-boomers age (the elderly comprise the largest group of chronic care patients) that number will continue to spiral upward.

Treating chronic care patients is costly because of the need for long-term treatments. Electronic Medical Records and the implementation of further Health Information

²³ Q. Ngo-Metzger, J. Telfair, D. H. Sorkin et al., Cultural Competency and Quality of Care: Obtaining the Patient's Perspective, The Commonwealth Fund, October 2006

²⁴ Keckley, Paul and Underwood, Howard. "The Medical Home." 2008. Deloitte Center for Health Solutions. 27 Dec 2008 <http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalHome_w.pdf>.



Technology would successfully reduce the costs associated with chronic care by reducing duplication and waste that result from poor communication.

Health Information Technology (HIT)

Widespread use of HIT in hospitals, community health centers, and private practices can result in health care savings. Meaningful use of HIT requires implementing standards of interoperability in addition to protecting the privacy of health records.²⁵

Ultimately, widespread adoption of HIT should accomplish the following: enhance data collection across relevant categories, expedite information exchange, reduce medical errors, improve coordination of care, increase patient engagement, improve health outcomes, and reduce health care costs.

Federal and state governments should support all necessary financial and technical assistance and training for small practice physicians. The cost for initiating EMRs in these settings should be covered by grant programs to avoid financial hardship and delays in small practice settings. Further, penalties should be eliminated and inflation-adjusted funds should be established to cover all costs of *implementation* and *maintenance* of EMR. Maintenance and trouble-shooting of EMRs is critical to the success of HIT adoption.²⁶

Comparative Effectiveness Research

Comparing and evaluating medical procedures, treatments, and technologies in terms of their cost and effectiveness can assist providers and patients in avoiding ineffective treatments.²⁷ The \$1.2 billion investment in comparative effectiveness research (CER) in the 'stimulus' bill underscores the administration's determination to document which treatments work and which do not, so that the system can stop paying for the non-performers, which sometimes end up being harmful to patients. The NMA's position on how to approach CER is outlined in Appendix B.

²⁵ Anderson , Gerard and Frogner, Bianca and Johns, Roger and Reinhardt, Uwe . "Health Care Spending And Use Of Information Technology In OECD Countries." *Health Affairs* 25, no. 3 (2006) 819-831 . Web.1 Jul 2009. <<http://content.healthaffairs.org/cgi/content/full/25/3/819>>.

²⁶ Bates , David W. . "Physicians And Ambulatory Electronic Health Records ." *Health Affairs* Vol 24, no. 52005 1180-1189 . Web.9 Jul 2009. <<http://content.healthaffairs.org/cgi/content/full/24/5/1180>>.

²⁷ Carey, Mary. "Comparative Effectiveness: Can It Really Cut Health Care Costs? ." *The Commonwealth Fund*. 2007. The Commonwealth Fund. 2 Jul 2009 <<http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2008/Jan/Washington-Health-Policy-Week-in-Review---January-7--2008/Comparative-Effectiveness--Can-It-Really-Cut-Health-Care-Costs.aspx>>.