Cries of Crisis: Rethinking the Health Care Debate analyzes decades of health care reform

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PROVIDENCE – Professor ROBERT B. HACKEY, PHD, [Brown ’92, political science and public policy], currently the Director of the Health Policy and Management Program, Providence College, has published extensively in the field of health care policy.

His latest book on the rhetoric of health care reform, Cries of Crisis: Rethinking the Health Care Debate, published by the University of Nevada Press in 2012, was recently released in paperback.

In it, Dr. Hackey examines the role the news and entertainment media and politics has helped shaped health care perceptions and debate over the past half century in this country. He argues the resulting rhetoric of crisis will not solve the complex and chronic financial and structural issues that beset the health care system in this country.

In the following Q&A with the Rhode Island Medical Journal, he summarizes key tenets of Crisis, framing the conversation through an Ocean State and national lens.

Q. How do you describe the current state of health care in this country and in RI, reframing it away from the decades-long terminology of “crisis?”

A. The US health care system doesn’t face a crisis – despite its problems, it’s not at risk of imminent collapse. Instead, the health care system is beset by a variety of chronic problems which must be managed, not cured. As we’ve seen in the wake of the Affordable Care Act, there’s no quick path to reach the IHI’s triple aim of improving population health, generating better patient outcomes, while simultaneously controlling costs.

Instead, policymakers [and physicians] need to focus on smaller steps that – taken together – will represent real, meaningful changes. This will be familiar to many physicians, who routinely treat patients suffering from a variety of distinct, yet related conditions. Imagine the US health care system as an obese patient suffering from diabetes, arthritis, hypertension, and chronic acid reflux. Crisis talk encourages us to look for magic bullets – a quick, effective, and decisive treatment – but improving quality, reducing malpractice risk, and controlling costs elude quick fixes.

Our current approach to health policy often fails to recognize the complex interrelationships among the problems we face. As a result, policymakers often unintentionally undermine the foundation of our health care system. As illustrated by the debate over the 2015 state budget, hospitals, physicians, and nursing homes operate in a climate defined by stagnant or declining reimbursement. For institutional providers, this puts pressure on staffing, which has a clear impact on the quality of care by raising the risk of preventable medical errors as overworked and stressed providers scramble to care for more patients. Physicians, for their part, face
growing pressure to see more patients each day, and now must track more patient data using electronic health records. Preserving the unique character of the doctor-patient relationship is a challenge in this climate. Shorter patient visits also affect the quality of care, as it is difficult for time-pressured physicians to coax patients into sharing all relevant information in a compressed visit, and if they do so, for doctors to have time to reflect upon and synthesize this information before moving on to the patient waiting in the next exam room. Our system does not reward physicians for spending “quality time” with patients.

Q. What are the top takeaways from your book, *Cries of Crisis*, the readership of the *Rhode Island Medical Journal* would be most interested in?

A. We need a better diagnosis of what ails the US health care system. Crisis talk is actually counterproductive, for it encourages policymakers to scramble to take decisive action to “cure” a variety of crises (e.g., rising costs, the uninsured, the shortage of nurses, and the rising cost of malpractice insurance). For more than forty years, different groups have defined the problems facing the US health care system as a crisis, but this diagnosis is inaccurate, and actually muddies the waters of public debate. Costs continue to rise, for example, but there’s no clear “tipping point” at which our spending on health care will reach an “unsustainable” level. Furthermore, despite repeated cries that we face a crisis in health insurance, more than 80% of Americans (and Rhode Islanders) are insured, and most insured patients express high levels of satisfaction with their access to care, the quality of care they receive from providers, and their coverage.

Health care reform reflects our expectations for the role government should play in our society. The health care system represents one-seventh of the US economy, so any efforts to control costs or improve access to care will have larger economic repercussions. At a time when trust in government is low, health care reformers must rebuild confidence that government is up to the task of reform. For me, that starts small – we need to take meaningful steps to expand access, control costs, and address quality problems to demonstrate that we can work together for a common purpose.

Q. What has been the impact of the ACA as you see it on providers and populace?

A. The ACA is really misnamed – a much better description would be the Accessible Care Act, not the Affordable Care Act. Affordability remains a challenge on several levels. We’ve subsidized the cost of private health insurance coverage through the ACA for individuals, but doing so comes at a high cost to the federal government, which picks up most of the cost for individuals and families who purchase coverage through state health insurance marketplaces. In addition, many of the private policies purchased through health insurance marketplaces such as HealthSource RI have very high deductibles, which leaves newly insured patients effectively underinsured (particularly if they suffer from one or more chronic conditions). High cost sharing actually discourages patients from seeking care in a timely fashion. We’ve made progress reducing the number of uninsured Americans – a significant accomplishment – but uncompensated care remains a huge issue for hospitals. Since the ACA has not achieved anything close to universal coverage – even in states such

Excerpt

Chapter One, “The Rhetoric of Health Care Reform”

p. 25: Cries of Crisis in debate over health care reform feature several complementary yet distinct stories of decline. As Deborah Stone notes, a story of decline typically begins with “a recitation of facts or figures purporting to show that things have gotten worse…What gives the story dramatic tension is the assumption, sometimes stated and sometimes implicit, that things were better than they are now and that the change for the worse causes or will soon cause suffering.” Crisis narrative promised supporters of health care reform a short-term political advantage by demanding immediate attention from policy makers. In the absence of a “meltdown,” however, repeated warnings of impending collapse were unpersuasive. In the end, narratives of crisis are counterproductive, for their rhetorical shortcomings offer ample opportunities for opponents to challenge, if not discredit, the need for significant policy change. The result, too often, has been stalemate.
as Rhode Island, where we embraced Medicaid expansion – providers still face the dilemma of treating many uninsured and underinsured patients. The state’s decision to cut Medicaid reimbursements this year was troubling, for it threatens access to care for publicly insured patients. In an environment of decreasing reimbursement, many providers in private practice can no longer afford to accept a substantial number of Medicaid patients. My fear with the continued erosion of Medicaid reimbursement is that more providers will opt out of the program, creating access barriers for patients. In addition, decreased participation by physicians in private practice will simply pass the burden of caring for publicly insured patients to community health centers and hospital clinics. Writing in 1988, Stuart Altman argued that “halfway competitive markets and ineffective regulation” defined the US health care system. Five years after the passage of the ACA, I think that still provides a disturbingly accurate description of where we stand.

Q. What state(s) offer the best example of providing quality and accessible health care and containing medical costs for its population?
A. The New England states have all done well in terms of expanding access to care (all have below average percentage of uninsured), but rising costs remain a concern across the nation. In particular, as we saw in Governor Raimondo’s budget this spring, every state struggles with the cost of Medicaid. Medicaid is one of the largest – if not the largest – line items in every state budget. Medicaid expansion offered a readily available path to increase access to care, but making it a centerpiece of the ACA’s efforts to expand access to care was an odd choice. As a joint state/federal partnership, rising spending on Medicaid places enormous pressure on state, which unlike the federal government, have a constitutional requirement to balance their budgets. Across the US – even in states which did not expand Medicaid eligibility – what’s known as the “woodwork effect” is contributing to significant increases in Medicaid spending that far outstrip increases in state tax revenues and overall spending. Outreach efforts succeeded in bringing many individuals and families who were previously eligible for Medicaid (but who had not applied) into the system. However, while the federal government pays 100% of the cost of newly eligible individuals (based on higher income eligibility thresholds), states must contribute to the cost of previously eligible enrollees at their existing Medicaid matching rate [FMAP]. This is a huge issue in states that did not expand Medicaid, but it’s also a challenge here in RI.

Q. The federal and state health-care exchanges – which is more viable in the long run for states in your opinion?
A. State-based exchanges have not achieved better results, across the board, than those operated in partnership with the federal government or managed exclusively by the federal government through healthcare.gov. The federal exchange offers economies of scale, with a unified web architecture that can be adapted for individual states. Despite the rocky rollout of the federal government’s web site in 2013, the performance of healthcare.gov improved markedly over the past two open enrollment periods. States have an important role in consumer education and outreach, and also in terms of regulating insurance markets, which vary considerably. Those tasks, however, don’t require states to establish, operate, and update web portals. Much of what we’ve spent on HealthSource RI over the past several years has been for IT consulting fees in an effort to create a “unified health infrastructure.” Going forward, without federal funds to defray these costs, I’m not sure that a state-based exchange is financially sustainable in RI and other states with relatively small individual – and small group – insurance markets. A state partnership marketplace, which preserves state control over consumer education, outreach, and regulation of the insurance market, may offer a more sustainable model in the long run.