# About Efficiencies Long Overdue, aka Not More Of The Same

*by Mavis Tuten*

At a hospital employee forum I attended the other day, a nursing supervisor disdainfully declared that President Obama wants to decide what doctor a person can see and what that doctor can choose to do. She indicated she knew this because she listened to the president's recent address to Congress.

Not having remembered the president saying this, I looked up his speech. It turns out that Obama's call for health care reform never touched on this specific. Rather, he said that quality, affordable health care for every American would be paid for in part by efficiencies long overdue in our system. He acknowledged there would be many different opinions and ideas about how to achieve health care reform, but he did not specify any particular method.

So, was it the "health care for every American" or the "efficiencies long overdue" or both that led my coworker to believe that a person's right to choose a doctor and a doctor's license to make medical decisions were being threatened? Why? Why would one assume that a system that provided health care to everyone by being more efficient would limit choices or care for some? And why, especially, would someone working in the current health care system suppose this? And why, if this is to be the case, would it be something to fear or deride?

## Examining Assumptions

Perhaps it's best to begin with the disingenuous assumption that our current health care system allows at least some people to choose their own doctors and gives those chosen doctors free rein to decide what is to be done. Even if a person's health care insurance has no preferred provider list of practitioners from whom that person can choose and puts no restrictions on what care that practitioner can prescribe, the reality on the ground limits choice.

One reality is that the practices of many primary care providers are closed. In other words, there is no room to squeeze another patient or another family into that physician's schedule—even with the tightest control over the time the physician is allowed to spend with any given patient. With influence or physician-finder services, those who have an urgent need or a good health insurance plan will probably get a physician. But this is not the same as getting a physician of choice. And this bit of reality applies only to those privileged with health insurance that the physician accepts. Those without health insurance or with an insurance plan not well liked by physicians have no choice but to go to the emergency room to seek needed medical care.

Another reality on the ground is that policies of insurance companies hold sway over the medical care that is allowable, and standards of medicine drive the care that a physician is able to bring about. The hope is that most of the dictates are derived from experience regarding what is medically efficacious and necessary. The acceptance is that some injunctions are based on factors such as cost, popular demand, successful lobbying, and profit and liability concerns, to name a few. The truth is that there are limits now on the care a physician can and does prescribe.

## A Failure Of Imagination

Perhaps the supposition that Obama's petition for health care reform calls for an abridgement of one's right to choose a physician and privilege of getting care based only on the physician's unconstrained medical judgment is based not on ignorance of the current health care system but rather on intimate familiarity with it. Perhaps it's a failure of imagination. Those who know best the status quo of our current health care system—such as my coworker—assume health care for every American means simply an extension of the current system to more people. Thus, if the current health care system restricts physician choice and controls medical care, logic suggests that incorporating more people into this system will compound those restrictions. The apprehension of a changed health care system may be based on an imagined health care system that has not changed enough.

Health care reform should not be about financing and making universally accessible the health care system we

currently have. Rather, it should be about revising the health care system to be efficient so that necessary medical care is available to all. President Obama was right in saying that efficiencies in our system that are long overdue will partially pay for quality, affordable health care for every American. He didn't go far enough, however. Efficiencies will not just fund quality affordable health care for all; efficiencies can make health care both quality and affordable.

Efficiency should serve as both the beginning and end of a new health care system—the blueprint for its construction and the test of its working out. How would one construct a health care system that uses medical practitioners, practices and resources to get the most output from input? And then, does that health care system actually get the most output from input?

It is neither within my wisdom nor the scope of this essay to present a draft of a new health care system here. What I can do, however, is outline some steps that need to be taken and some considerations that ought to be incorporated in the plan of a new system.

## Define The Output

The design needs to start with defining the output wanted from the health care system. I believe we start at a disadvantage due to the use of the term "health care" to refer to "medical care"—more specifically, to refer to a system of Western, scientifically-based treatments of biological diseases and disorders. A true health care system would focus on more than the scientific treatment of biological disease and disorder; it would also address many of the causes of those diseases and disorders to include personal, cultural, environmental and political forces that are not amendable to biomedicine alone. The fact that health care and medical care are widely used as if they had a common meaning, however, gives more impetus to the necessity to clearly define the output we intend to pursue from a re-envisioned health care system. Without this, we will have multiple strategies, each of which may achieve some good in the end, but none of which will bring about a shared agreement of a common good to be accomplished.

Regardless of the overuse of the term health care, we should begin to define output, for the purposes of a societal-sponsored health care system, in terms of the biomedical care to be available to all persons. This means that our health care system is not primarily going to be about eradicating poverty and homelessness, providing clean air and water, and promoting egalitarian social conditions. Rather, it's going to define the medical care we make available to members of our society.

Perhaps surprising to many, we currently have universal access to medical care in America. The problem is that the care offered to all seems to have been selected for its inefficiency in managing chronic diseases. Anyone who happens to have a seizure can get the emergency and critical hospital care needed to treat that seizure; only those with money or means can get the anti-seizure medications that might have prevented that seizure. Likewise, anyone who is struggling to breathe due to an asthma attack can get the emergency medical care needed to save his or her life at that time, but the asthma-control medications that might have prevented the attack may be out of financial reach. We need to give priority to making broadly available the care that efficiently manages diseases, rather than the efficiency with which we deliver limited instances of critical care to treat acute exacerbations of disease.

## Using The Efficiency Model Effectively

The efficiency model needs to be used to determine not just the medical care we make available to all, but also the means by which that care is rendered. We overutilize physicians and underutilize medical professionals such as nurses, pharmacists, dieticians, social workers and therapists (physical, occupational, mental health, et al). We ask patients to come to a 15-minute visit at a private physician's office to monitor their disease rather than sending nurses to those patients' homes. We expect

physicians to prescribe, teach, counsel and answer questions and we assume patients can monitor and manage the prescribed care. For inexplicable reasons, we fail to see that such work is outside the time and inclination of physicians and beyond the capabilities of many patients and families. We could look to hospice as an example of how efficiency can actually bring about more and better care.

As we move forward with a goal of health care for all Americans, we need to remember that "efficiencies long overdue" is the key to re-envisioning a health care system that can provide more health care but not more of the same health care. The derisive idea that health care reform means less choice and care is based on a failure to imagine that things can and ought to be done differently.

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