The Paradox of Public Policy Reform: Change or Continuum?

This is shaping up to be a watershed year for public health reform. Pressures of cost, quality, and access that have been building up under the healthcare boiler are about to produce their own peculiar set of eruptions, and the American healthcare system will look far different once the ensuing systems changes have taken effect. As they come into play, it will be instructive to keep an eye on the prize: will these changes favor cost, quality, or access, or will they produce the desired balance between them? In like fashion, will there be obvious winners and losers in the wake of these reforms, or will the needs of all stakeholders be accommodated? Above all, is public policy the dominant force stimulating healthcare, or simply the final stage in it?

Mankind’s needs are infinite, and so, it would seem, are those of the healthcare system. Several front-runners for the foreseeable future are: biosimilars legislation, comparative effectiveness research (CER), funding of the National Institutes of Health (NIH), and Medicare reform.

Expect federal legislation to create a new regulatory pathway for approval of biosimilars. This must be done carefully to prevent a disincentive for development of new biologics. More than 40% of Medicare Part B spending on biologics is for oncology drugs. How will Congress use the projected $6 billion in federal savings? CER has moved, somewhat precipitously, from a good idea to a serious proposition, displacing evidence-based medicine as the perceived “best of all possible worlds.” It remains to be seen how, and how efficiently, the federal government will spend the $1.1 billion earmarked for CER. What matters now is setting research priorities, and the influence that CER will have on coverage and reimbursement decisions in Medicare, Medicaid, and private health plans.

The economic stimulus bill injects $10 billion in additional funding to NIH over the next 2 years, and President Obama has proposed to further increase NIH-funded cancer research as part of a multiyear commitment to double cancer research funding.

Medicare reform all by itself would have been a sufficient challenge; adding it to these other issues makes it all the more compelling, given the wide range of issues facing policymakers. Unless Congress acts to reform the Medicare physician payment formula, physicians will suffer a 20% fee cut in January 2010. Because this is obviously untenable, Congress knows it must act to fix payment rates, but it also knows why the problem has remained unresolved: it could cost more than $250 billion to bring payment levels up to real-world provider needs. Meanwhile, many on Capitol Hill are also eager to cut payments to Medicare Advantage plans and create a government-run “public plan” to compete with commercial health and drug plans in Medicare.

The American healthcare system is a force for extraordinary progress. Cancer outcomes have never been better. The United States is a powerhouse for new drug development. Quality-of-care measures are being pursued by payers, providers, and purchasers at an unprecedented rate. Each stakeholder group is hard at work identifying ways to bring value—that amalgam of cost, quality, and access—to healthcare. As American demographics and evidentiary standards change, it is important to take a step back to gain perspective on how well we have been allocating precious healthcare resources to date. Public policy reforms are needed, but they hardly act in a vacuum, as clinical and business system changes and best practices define how public policy can support them. The view should be constructive, optimistic, and collegial. At its core, the American healthcare system is strong for the very reason that it insists on improving a good thing.

As policy is proposed, it should be done in recognition of the need to preserve, not shatter, a system with the flexibility and tenacity to demand improvement and the strength to achieve it. The public policy reform that is about to take place has been brewing for a very long time, proceeding along lines established over the past decade, often by the other 2 legs of the triangle—the clinical and business sectors. If action is to take place on the government level, it would be a mistake to conclude that we need a government-dominated healthcare system—that government could solve what the clinical and business sectors could not. Rather, public policy should conclude the issues defined for it by the clinical and business sectors, thereby fulfilling its proper role in the triad of forces that have always driven healthcare.

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