



## Health care policy and advocacy:

### *A call to arms for residents and associates*

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**A**s quickly as medical discovery and advancements in care occur, so do developments in the health care policy front. Recent events in the political arena have created a tumultuous maelstrom of bill proposals, amendments, legislative committee meetings, and a presidential health care summit, which, following more than a year of partisan and intra-party debate, culminated in the Patient Protection and Affordable Care Act (H.R. 3590), which was signed into law. Despite the reality that health care reform is now law, general public disillusionment with how the law will impact society and with the government's ability to implement the law continues—regardless of political party affiliation. A recent *Newsweek* poll of 1,009 Americans solicited the public's opinion on the government's handling of the issue of health care reform. President Barack Obama's approval rating was 39 percent; the Congressional Democrats' rating, 27 percent; and the Congressional Republicans' rating, 21 percent.<sup>1</sup> Health care reform continues to be the Sisyphean boulder on the backs of the American people and our political system.

#### Generation “why?”

Legislative politics has traditionally struggled with engaging younger generations to participate in the process. This same paradigm exists in getting residents and young surgeons involved in health care advocacy. Many Baby Boomers have accused Generation X and Generation Y of being different, although evidence to the contrary exists.<sup>2,3</sup> Those individuals graduating from the new regimen of an 80-hour work week are often challenged on their personal commitment to patient care, devotion to career, and professional focus. These challenges persist, despite the fact that work-hour restrictions were not requested by, but imposed on, residents due to circumstances surrounding their predecessors. The end results of the work-hour restriction are questionable, but what is generally agreed upon is that educational time is more limited, and contact time with faculty has been reduced.<sup>4</sup> This further strains the dissemination of knowledge, especially in the political arena. Opportunities

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for political mentorship and simple water cooler conversation about current health care advocacy efforts are rightly pushed aside for discussions on patient care, educational issues, and disease management.

More challenging is the fact that many residents are not even equipped with the vocabulary to carry on the conversation. Trainees tackling their daily tasks of rounding, operating, and caring for patients are left limited time to remain well-versed on the political front. Without guidance from their faculty, many trainees are left unaware of the reasons why awareness of current health care advocacy efforts is necessary, and, more importantly, why these efforts require the involvement of young surgeons.

### An appeal to residents and associates

It cannot be emphasized enough that the involvement of young surgeons is crucial to the current political process of health care reform. Any reform put into action today will have little effect on senior policymakers from the major medical societies, or on those in Washington, DC. The impact will be felt by the current youth in medicine, who will live and practice for years in the environment created by current health care policy, and will have to contend with future ramifications of any potential new legislation.

The Balanced Budget Act of 1997 helped to enact Medicare's sustainable growth rate formula (SGR). An oversimplified description of the SGR is that it ties the physician payment rates for Medicare-related services to the growth of the economy.<sup>5</sup> When this legislation was enacted, the economy was performing well, but it has since declined, while health care costs and expenditures have soared. The SGR addresses this financial shortfall by reducing overall physician payments in an attempt to maintain fiscal neutrality. The impact couldn't have been more profound. Since 2002, there has been a planned Medicare cut associated with every fiscal year. Congress has stepped in to prevent the cuts, but it has avoided addressing the baseline flaw in the SGR formula. Even while cuts have been averted, the largest fee increase has been only 1.5 percent. Many years have seen a 0 percent to 0.5 percent in-

crease.<sup>6</sup> With health care costs far exceeding the rate of inflation, the SGR has resulted in a sharp decline in physician reimbursements for Medicare-related care.

A 21.2 percent cut in Medicare, which was scheduled to take place on January 1, was temporarily stayed for 60 days in late December 2009, and on March 1 was stayed again for an additional 30 days (which expired April 1). Unfortunately, at press time, a permanent solution to this issue was not yet available. Legislators have been paralyzed to the point of inaction. Fear that a permanent repeal of the SGR will result in accusations of increasing government financial debt and burdening future generations are juxtaposed by the premise that allowing Medicare cuts to occur will create an impending crisis, leaving a large section of American seniors with a lack of health care coverage and access to physician care. As a result, the myriad patchwork fixes continue, with no future plans in sight for overhauling the system.

The impact of the SGR is far-reaching. In previous years, where cuts have been actually allowed to take effect for short periods of time, physicians responded by cutting appointments to new Medicare patients. Some practices even dealt with the crisis by temporarily closing their doors, having been unable to cover the operating costs of their practice.<sup>7</sup> On a national level, patients could suffer severely, with potentially few doctors remaining enrolled as Medicare participants. Only after graduation from residency and upon joining my practice did I realize the scope of this issue. Medicare covers 35 percent to 40 percent of my own practice's patient population. Like many other groups, a 21 percent decrease in reimbursement would cripple our practice, requiring employee layoffs, a reduction in patient access, and limiting of surgical services. It is ironic that legislation that was enacted while I was college, and had remained relatively unknown to me through 10 years of medical training, now stands poised to severely transform my ability to provide care in the profession I have grown to love. Many of my own residents have asked me, "How can I afford to spend time keeping up with everything going on in Washington?" My response is simple: "How can you afford not to?"

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## The College's role in health care reform

The mission statement of the College is, "The American College of Surgeons is dedicated to improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment."<sup>8</sup> The College, representing more than 77,000 members, has been instrumental in supporting these issues in Washington. However, the plea for simple improvements in physician reimbursement alone will fall upon deaf ears in Washington, DC, and does not actually satisfy our duty as surgeons. It is our obligation as health care providers to participate in the reform process, assure patient access to quality surgical care, and continue to advocate for our patients' rights. In general, the public trusts physicians to carry out this task. In a Gallup poll of 992 Americans, 77 percent felt confidence in physicians to recommend the right course of action for health care reform. Comparatively, the President scored 49 percent, Democratic congressional leaders scored 37 percent, Republican congressional leaders scored 32 percent, while health insurance companies inspired the least confidence, with a 26 percent rating.<sup>9</sup>

The ACS 2009 Statement on Health Care Reform is an eight-page document detailing the

College's position on issues related to health care policy.<sup>8</sup> The College adheres to the tenets of its mission statement by promoting four key principles that any health care reform bill must comply with, and they are as follows:

1. *Quality and safety.* The College has been deeply rooted in the history of patient safety, beginning with its development of the *Minimum Standard for Hospitals*, published in 1917, and with the creation of the Joint Commission on Accreditation of Hospitals in 1951, which is known today as The Joint Commission.<sup>10</sup> Since that time, various College programs seek to improve the delivery of surgical care in America. The ACS National Surgical Quality Improvement Program (NSQIP) helps to avert surgical complications, improve patient safety, and deliver quality care. In addition, by reducing complications, millions of dollars are saved in health care costs. Other issues supported by the College include responsible-use physician quality data and public reporting that is accurate, risk adjusted, peer reviewed, and developed with surgeon participation.

2. *Patient access to surgical care.* The College's Operation Patient Access is a program that has been formed by a coalition of surgical groups with the goal of addressing the pending surgeon shortage and preventing limitation of access to surgical care.<sup>11</sup> During the 1980s and 1990s, various policymakers predicted a surplus of physicians entering the workforce. As a result, several steps were undertaken to reduce the number of doctors graduating per year.<sup>12</sup> No one could predict the size and scope of the pending surgeon workforce crisis that now looms near in the profession's future. Nearly a third of rural hospitals expect to lose a general surgeon within two years, while a third of rural hospital administrators are looking to hire a surgeon.<sup>13</sup> By 2012, a predicted 40 percent of trauma surgeon positions at Level I and Level II centers will remain unfilled.<sup>14</sup> These are just some of the factors that threaten a patient's ability to gain access to potentially lifesaving surgical treatment.

3. *Medical liability reform.* Medical liability reform has been demonstrated to be beneficial in several states, and, thus, it is supported by the College. Caps on noneconomic damages help to draw physicians to states with lower malpractice premiums, reduce budgetary expenditures in

### Additional ACS resources for health care advocacy

The ACS has a variety of resources available to help educate, disseminate information, and activate the surgical workforce in the area of health care policy reform. For more information, visit:

- American College of Surgeons main health care reform page: Available at: <http://www.facs.org/hcr/index.html>
- American College of Surgeons Division of Advocacy and Health Policy: Available at: <http://www.facs.org/ahp/index.html>
- American College of Surgeons 2009 Statement on Health Care Reform: Available at: <http://www.facs.org/hcr/acs2009hcr.pdf>
- American College of Surgeons Operation Patient Access: Available at: <http://www.operationpatientaccess.facs.org>

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health care costs, and improve patient access to care.<sup>15</sup> States lacking noneconomic caps create a disincentive for surgeons to practice in a region, resulting in a lack of surgical availability. Other components of liability reform include alternatives to litigation, protection of physicians working in disaster situations, and protection of those physicians adhering to evidence-based guidelines.

4. *Reduction of health care costs.* The College seeks to improve the quality of surgical care delivery, thereby reducing complications and decreasing health care costs. In addition, evidence-based guidelines will eliminate waste, cut costs, and improve health care system efficiency. New forms of physician payments are also supported, provided they are voluntary, sustain a viable workforce of surgeons, and improve patient care.

### Differing needs for residents and associates?

The current political climate has centered on patient access to quality care, and providing reasonable health care coverage. However, there are a number of issues that remain unaddressed in the prevailing conversation. The increasing debt carried by medical students is severely impacting the choice of medical training, practice location, and overall job satisfaction. Recent data from the American Medical Association states the average debt from the class of 2009 is \$156,456. Over the last 20 years, private schools have raised tuition an average of 50 percent, with public institutions increasing fees by 133 percent.<sup>16</sup> This issue, coupled with decreasing physician reimbursements, threatens to deter quality individuals from entering the medical profession. The effect of education debt can be alarming, with 32 percent of academic surgeons choosing not to recommend their career choice to their children or to medical students.<sup>17</sup> The College stands in support of loan forgiveness programs and expansion of the National Health Service Corps to include surgical disciplines with anticipated workforce shortages.<sup>8</sup> This is an important first step, but further action must be taken to address the indebtedness of American medical graduates.

There is an overall lack of discussion regarding funding of resident training. The Balanced Budget Act of 1997 enacted caps on Medicare's Direct

Graduate Medical Education payments used to cover the cost of resident education.<sup>18</sup> Since that time, however, the number of graduating residents has remained largely stagnant. Hospitals and residencies have attempted to address the issue via funding sources from private grants and internal institutional monetary sources. This overall lack of focus on resident funding fails to help address the pending surgical workforce shortage, which will impact access to effective and quality surgical care.

### How to get involved

The time to get involved is now. The College is a unique organization, and through the Resident and Associate Society (RAS) you can become part of the solution. It is one of the few medical organizations that is inclusive, rather than exclusive; if one wants to participate, they can. The RAS Issues Committee helps to address matters of health care policy. There is also the RAS liaison program, which puts a RAS representative in each institution with resident trainees. At the local level, identify mentors active in health care policy and find out how you can help them. Participating in your local ACS Chapter meeting or medical society is a great way to seek out those individuals. Become active in your institution by volunteering for hospital and medical school committees. Contact your local state and national representatives to let your voice be heard. The College sends its members legislative alerts and updates, which make this process easy.

### Summary

The College supports the efforts to provide universal access to quality, timely, and affordable surgical care. President John F. Kennedy once said, "There are risks and costs to a program of action. But they are far less than the long-range risks and costs of comfortable inaction."<sup>19</sup> It is imperative that, as patient advocates and practitioners of the art of surgery, we let our voices be heard on this matter. The issue of health care reform is both complex and diverse, requiring thorough debate. Like many major movements throughout history, this issue also requires action, perseverance, and courage. □

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