Dr. Timothy Harrington: Which health care proposal makes sense for America?

- By Dr. Timothy Harrington | guest columnist, Sep 13, 2019

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The Democratic presidential debates about health insurance are offering primary voters with two alternatives: replacing private insurance entirely with a government-managed plan similar to what Medicare provides to senior Americans now, or allowing citizens to choose between their current insurance and a public option within the Affordable Care Act insurance exchanges.

In either case, Americans in poverty would receive government subsidies to make adequate insurance affordable. The first alternative proposes to replace the current for-profit health insurance industry and employer-based insurance with a government-mandated, tax-funded, single-payer system, while the second would allow employers and citizens to choose their best insurance options over time.

My preference, as a physician with 50 years of experience in practice and medical administration, is to add the "public option" to the Affordable Care Act as a first step toward creating the high-value, affordable, universal health care we all desire. Here's why.

Advocates of "Medicare for All" believe it will work better for everyone, and cost a lot less. Their belief is based on how single payer systems have functioned in other countries, and how Medicare enjoys high ratings from older Americans. They fail to recognize that other countries' delivery systems were built to provide high-value, affordable health care for all, rather than to maximize revenue and profits for corporations and delivery systems, as is generally true here, or that Medicare payment rates do not cover the costs of the care provided to Medicare patients. Universal Medicare rates could be especially devastating for financially-strapped inner-city and rural health systems.

“Public option” advocates believe instead that adding onto Obamacare is a pragmatic first step toward achieving universal access to health care — change by evolution rather than revolution. This incremental approach recognizes that changing incredibly complex systems such as our health care financing is best approached with step-by-step tests of change. This would give delivery systems and health professionals time to adjust to these shifting financial realities and would reduce unintended consequences. A marketplace competition would rapidly determine whether Medicare for the currently insured would actually work better than what they have now. It’s a fair bet that employers and the public will choose the insurance that provides better access to more care at a lower cost, and that private insurers would have to become more competitive or go out of business. In the end, hospitals and medical practices will only provide necessary care to everyone at an affordable cost by transforming how care is provided, as my colleague and I described in the recently published book, "Great Heath Care Value."

In fact, high-capacity, high-access, less costly health care is already being provided in a few exceptional American medical practices that have built interdisciplinary teams and adopted disease population management processes to replace traditional approaches. Their patients are healthier, and experience on-time care, fewer hospital admissions and less waste. These practices care for many more patients per physician at a lower per-patient cost, which translates into higher profits and/or lower prices.

Americans need to understand these advantages and insist that this high-value care becomes the rule, rather than the exception, no matter how we decide to pay for it.

Dr. Timothy Harrington is a physician and health care consultant from Madison.