EDITORIAL AND COMMENT

Physicians, Politics, and Health Insurance Expansion

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Physicians carry conflicting feelings about expanding health insurance coverage. On the one hand, the service ethic of the medical profession embraces the provision of medical care for all who need it. On the other hand, the inevitable increase in governmental authority that accompanies health insurance expansion threatens to interfere with the independent practice of medicine and to curb physician payment and income. In weighing these two imperatives, physicians have historically opted for opposing government expansion of coverage. Three examples illustrate this tendency.

In the United Kingdom, physicians strongly opposed the 1946 National Health Service Act. But Prime Minister Aneurin Bevan famously overcame that opposition by “stuffing their mouths with gold—increasing physician income at a time when it was precariously low. In 1962, physicians in the Canadian province of Saskatchewan conducted a 23-day work stoppage in opposition to the provincial Medicare program. The strike was unsuccessful, and the program became the model for the eventual Canadian Medicare single payer system. Physicians in the United States, led by the American Medical Association (AMA), waged a long and successful campaign against any governmental role in health care insurance until the 1965 legislation that enacted Medicare and Medicaid over strong AMA opposition. Wilbur Cohen, then Under Secretary of Health, Education and Welfare, tried to placate the AMA by writing into the Medicare legislation the inflationary physician payment schedule of fee for service according to “usual, customary, and reasonable charges,” but to no avail.¹ Two subsequent expansions of health insurance in the United States, the State Children’s Health Insurance Program (SCHIP) and Medicare Part D for drug coverage passed with bipartisan political support and minimal physician opposition, probably reflecting the incremental and age-specific nature of these programs, which were not perceived as threatening to either physician income or autonomy.

The passage of the Patient Protection and Affordable Care Act of 2010 (the ACA or “Obamacare”) split starkly along partisan lines, garnering zero Republican votes in either the House or the Senate. Yet, in comparison with the

Clinton 1993 effort to expand health care, the opposition of organized medicine was less intense than it had been to earlier health insurance expansions, allegedly reflecting concessions made by the Obama administration regarding the Sustainable Growth Rate penalty on Medicare physician payment as well as malpractice reform. This issue of JGIM features a survey by Antiel et al. of 2,556 physicians who in 2012 were asked their opinions about the ACA in general and what it might foretell for physician reimbursement.² Additionally, they were surveyed about beliefs concerning social responsibility and professional obligations. Of note is that the survey was conducted at a time when Obamacare was a major issue of contention in the 2012 presidential campaign. The sample is generally reflective of American physicians today, but not tomorrow: male (70 %); over age 50 (58 %); and white (77 %). Surprisingly, 40 % of the respondents were from primary care specialties, not defined. Politically, the distribution was not dissimilar from the country as a whole—38 % described themselves as conservative, 30 % as liberal, and 29 % as moderate or independent. And attitudes about the ACA were also not that different from national polls, with 58 % opposed and 41 % supportive. Regarding the ACA’s impact on physician reimbursement, 44 % felt it would be less fair, 7 % more fair, and the remainder were uncertain.

Respondents were also queried about three aspects of professional obligations regarding social responsibility: whether addressing health policy issues falls within professional obligations; whether there is an obligation to care for the uninsured and underinsured; and whether coverage should be limited for expensive drugs and procedures as a way to expand access to basic health care. Not surprisingly, those who favored the ACA were significantly more likely to agree with each of these three theoretical professional obligations, though whether those agreements translated into actual practice was not probed.

Analyzing the responses by physician characteristics yielded predictable results. Self-identified liberals and moderates were both much more likely to support the ACA and to believe it would make physician reimbursement more fair. Physician specialties generally stereotyped as being more conservative (e.g., surgeons and procedural specialists) were both less supportive of the ACA and more threatened by potential reimbursement changes than those classified as primary care. Data on specific specialties were not presented.

The Antiel survey results parallel those of the 2012 presidential election, in which public attitudes about the ACA broke strongly along party lines. Almost 80 % of Obama voters said that the ACA should either be expanded (49 %) or kept as is (29 %), and 92 % favored continued federal government efforts to assure health care coverage for most Americans. By contrast, only 10 % of Romney voters favored expanding (3 %) or retaining (7 %) the ACA, while the great majority favored either repealing all (48 %) or some (36 %) of it, and only one-third of Romney supporters agreed that there should be a federal role in assuring health care coverage.³

The Antiel snapshot of physician attitudes about the ACA raises at least three questions. Will the changing demographics of American physicians modify their previously political conservative tendencies? Who now speaks for American physicians? And what will be the impact of the ACA on physician income?

Although physicians have generally been felt to harbor conservative political views and to vote Republican, as the profession moves toward gender parity, it is likely that those tendencies will modify. Currently, there is a major national gender voting gap, with 55 % of women voters having supported Obama in 2012, compared with only 44 % of male voters. And white male voters (the largest bloc in this survey) were even less likely to vote for Obama (39 %). How this expected swing toward a more politically liberal medical profession will manifest itself in preferences about health policy is unclear.

During the twentieth century, the American Medical Association was perceived as the voice of the medical profession, but even though it still retains a strong presence in Washington DC, its claim to represent American physicians is challenged by the steady decline in AMA membership. According to a recent article by Collier in the *Canadian Medical Journal*, membership in the AMA was as high as 75 % in the early 1950s, but today its total membership is below 216,000, with one-third of those comprising partial dues paying medical students and residents.⁴ Thus, Collier estimated that only about 15 % of practicing U.S. physicians now belong to the AMA today. What accounts for that decline? Likely, it is a result of the lure of medical specialty and subspecialty societies, to which most physicians feel a closer allegiance, as well as a general societal move away from joining membership organizations. Because the medical profession is now more diffused among these specialty groups, it is unlikely that it can sing with a single voice, especially absent a designated conductor. This will likely further attenuate the influence of physicians in health policy, to the benefit of health economists and other special interest lobbyists.

Finally, whether or not the potential cost containment features embedded in the ACA are fully realized, it is likely that changes will occur in how physicians are paid, spurred by the realities that the growth in expenditures for medical care is unsustainable. As Lewin recently stated, there is a growing policy consensus that payment reform must be at the heart of restoring financial stability to Medicare and Medicaid, and private health insurers take their cue from federal programs.⁵ Whether this will mean the phasing out of fee-for-service payment to physicians, to be replaced by various forms of bundling or capitation, or merely a recalibration of payment valuations in the direction favored by the primary care physicians and feared by the surgeons and proceduralists in the Antiel survey, remains to be seen.⁶ It is likely that some form of relative value payments will be retained, but in a different configuration.⁷

Does this mean that physicians are destined to be squeezed out of health policy deliberations? I hope not, because physicians still bring unique authority regarding the quality, value, and composition of health care. It is likely, however, that physician influence will depend on specific opportunities to express their voices, rather than speaking as a unified bloc. Given that the results of the Antiel survey show that physicians are just as polarized in their politics as the rest of the country, that should come as no surprise.

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