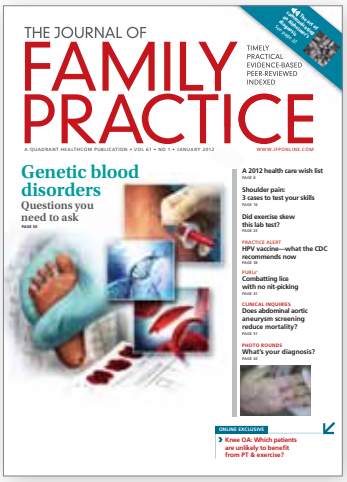
20 years later, not much has changed



A basic universal health care package for every US citizen was at the top of Dr. Susman's 2012 health care wish list (Editorial, *J Fam Pract*. 2012;61:8). Ironically, it was No. 1 on my list, as well, when I wrote the following for *Kansas Medicine* in 1992:

"Universal access does not imply access to all health care, but to basic health care which includes disease prevention and health promotion, treatment of acute illness and injury, management of chronic illness, and comfort care for the preterminal and terminal patient."[1] By reducing the cost of administrative waste, unnecessary care, and sometimes overpriced care, I added, we might find the money to cover basic—and reasonably beneficial—care for all.

It is painful to realize that citizens of all other industrialized nations already enjoy universal health coverage. People in these countries realize their systems aren't perfect, but absolutely don't want ours. Often, they're appalled to learn that some Americans don't get needed care because of financial issues and others are forced into bankruptcy because of health care charges.

There were just 4 items on the list I wrote 20 years ago. The 3 detailed below, like the first one, are issues our nation still faces today.

Public support for health care. My point was that tax dollars should become a larger source of funding for health care services—with a CEO contributing more than a janitor. Although it is getting more expensive to provide care for seniors, it is unlikely that our country will ever move away from tax-funded support of health care for the current Medicare and Medicaid populations.

Equitable physician payment. In the 20 years since I wrote that, little has been done to level the playing field between primary care physicians and specialists. Population-based studies reveal that health outcomes are best in systems founded on strong generalist physician care. Physician training and reimbursement schedules must change to produce a strong base of generalist physicians.

Professional liability reform. This may be even more important now as we strive to provide cost-effective care amid a flood of unnecessary studies ordered in a poorly thought-out effort to help ensure that we don't end up in malpractice court.

The practice of medicine is harder today than it was 20 years ago. But the opportunity to sometimes cure and always care for our patients still makes me happy to get up and go to work every day.

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1. Anderson L. Health care reform: a 'consciously incremental approach.' *Kans Med.* 1992;93:103-104.

The FDA should mandate that all metered-dose inhalers come with a built-in spacer. This would greatly improve compliance.

Inhaler use: Tell patients to purse their lips

I would like to add another major error to those cited in "Inhalation therapy: Help patients avoid these mistakes" (*J Fam Pract.* 2011;60:714-720): Patients often shove the mouthpiece into their mouths, which prevents them from getting a good inhalation.

I demonstrate to patients that just pursing your lips loosely around the mouthpiece and inhaling allows air from around the mouthpiece to enter, increases the airflow, and moves the medication farther into the lungs.

The Food and Drug Administration should mandate that all metered-dose inhalers (MDIs) come with a built-in spacer. This would greatly improve compliance—especially among elderly patients, who often have difficulty using MDIs properly. For a few cents each, thousands of dollars could be saved by a reduction in patient visits to emergency rooms.

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