

Our National Health Care Plan: Don't Get Sick!

A 2-3 installment article (depending on space available in newsletter)

-----First installment

There is a growing awareness that our health care system is awash with mounting problems. These problems include underuse, overuse, and misuse of health care services. We see evidence of such problems in small and large communities alike, in all parts of the country, and with about equal frequency in managed care and traditional institutes of care. Left alone, these problems represent a major disruption in our country, in both economic and human suffering.

In 1900, a person could expect to live into their late 40s. Today, there are 7.5 million people in the United States who are 80 years of age and older. Census Bureau estimates predict that by the year 2020 this group will increase by almost 75 percent to 13 million. Up to 70 percent of this group has at least two coexisting chronic conditions, such as arthritis and diabetes. Caring for these chronic conditions consumes \$1 of every \$6 spent on health care.

At the core of the problem is a fundamental shift in health care economics. Increased competition and cost-consciousness in the "medical industrial complex" are eroding the traditional "Robin Hood" system for financing and delivering care for the poor and under- and uninsured without establishing a new method of ensuring access to care.

Historically our mechanism of financing care to the under- or uninsured was based on a premise of "financial slippage" in the system. The system functioned because hospitals and other providers were willing to care for people who did not pay, insurance and other payers were willing to pay a little extra to help cover the bills of the uninsured, and people were willing to pay higher premium costs to help subsidize the care of those with higher anticipated health care risks or larger families. However, precisely because of

improved cost containment and tightened management of our health care resources we are now building into a crisis of national magnitude by failing to create a new mechanism to assure access.

A recent Institute of Medicine report warns that current efforts to improve U.S. health care will not succeed without a major, systematic effort to overhaul the delivery of health care services, education and training of clinicians, and assessment and improvement of care quality. The report cites underuse, such as missed immunizations or missed opportunities to detect and treat diseases such as hypertension or depression; overuse, such as prescribing an antibiotic for a viral infection like a cold; and misuse, such as avoidable complications of surgery or adverse drug events. Fee-for-service plans encourage overuse; capitation payments, common in managed care plans, encourage underuse. No current payment system systematically rewards excellence in quality.

(Next Issue: Who Gets Hurt by Our Health Care)

-----2nd Installment

(In the previous installment we looked at how issues of “cost” in our health care system had led to problems in “access” and greater disease and suffering. In this installment we examine who gets hurt most.)

“We must protect the children” is the battle cry heard from Austin and Washington and there have been some minor successes. The recently passed Child Health Insurance Program contained in the Balanced Budget Amendment provides hope that States will be able to extend insurance to as many as half of the Nation’s uninsured children. However such efforts are still insufficient as long as the issue is “cost” over “access”.

Women and children, the poor, the “near-elderly” and minority groups are particularly effected by the change in health care delivery. A recent government publication found that health-related problems among children are strongly linked to such socioeconomic factors as race and ethnicity, parents’ education, and parents’ employment. In 1996, nearly 11 million children were uninsured. A substantial number

of American children are uninsured, have difficulties with access to care, or are in poor health. Hispanic children, children whose parents have little education, and those living with families without an employed parent are disproportionately likely to encounter these problems.

The near elderly—those older than 50 but younger than 65—were more likely to suffer a decline in health, the loss of a spouse, and/or to leave the labor force via early retirement than younger people. Thus, people in this age group are at increased risk of losing their health insurance coverage. Despite efforts to provide and protect the near elderly the proportion of near elderly in the U.S. without public or private coverage has remained constant at 11.2 percent from 1992 to 1994.

If you are black or female, your chances of receiving a major diagnostic or therapeutic procedure while in the hospital is far less than if you are white or male according to researchers. Black women had a significantly lower rate of therapeutic procedures than white women for nearly all female reproductive system diseases. Blacks had a significantly lower rate of therapeutic procedures than whites for several common cancers such as colon, bladder, cervical, and breast cancer.

Searching for other mechanisms of funding for non-health related government projects the State of Texas is attempting to sharply reduce monies available for health services from the recently negotiated \$17.3 billion settlement from the tobacco companies. \$200 million of the proceedings has been earmarked for smoking-related programs but, under related legislation, the money would be in the form of an endowment, and only the earnings—an estimated \$20 million over the next two years—would actually be spent to fight smoking. An additional \$179 million would go to the children's health-insurance program, which is designed to expand health coverage for children of the working poor. Cindy Antolik, director of government relations for the American Cancer Society's Texas division notes Governor George W. Bush's position on the issue has been "at last check, ...aggressively neutral." State Sen. J.E. "Buster" Brown, Republican from Lake Jackson, has proposed that a large chunk of future tobacco settlement payments be used to back bonds for roads,

bridges, schools and other projects. He argued that highway safety, which would be affected, could be considered a health-related issue.

(Next Issue: Possible Solutions)

-----3rd Installment

(In the first two installments of this article we examined how new management practices in health care have transformed our access to services. We also reviewed who were most at risk in this new system. In this final installment we examine possible solutions to the problem)

All of us have had to alter our utilization of health care services as methods of cost containment have been put into place. Service models have moved from a preventative approach to a “crisis intervention” nature. Even services that are covered may not be, in reality, available as guidelines of care make it difficult to access these services. Blue Cross/Blue Shield of Virginia is currently being sued by a consumer group claiming deceitful trade practices in that services promised were actually not available due to restrictive guidelines and pre-authorization requirements. With cost remaining the primary factor in the design of our evolving health care system this problem is likely to become compounded.

What can be done? The obvious need is for developing a fiscal mechanism that will ensure access while appreciating the need for cost containment. A second need is to refocus on issues of primary prevention in place of the more costly “wait till it breaks” philosophy. Streamlining Medicaid and Medicare administrative procedures (eligibility, treatment approval) could contribute to better care. For example, instituting a mechanism for prior approval of care once a child or other person appears for his or her examination would help to ensure that all needed care could be completed quickly and without the need for further approvals.

Several bills pending in Washington include health care priorities such as:

- *Legal accountability for managed-care plans
- *Patient appeals
- *Determination of medical or clinical necessity

*Patient choice of provider

*Patient access to a range of providers

While these bills are sponsored by both parties the Republican versions just don't go far enough by containing large loopholes and exemptions. It is largely democratic leaders who have sponsored bills that provide the strongest direction in solving this problem. 9 States have passed legislation requiring that managed care plans disclose financial incentives they offer participating physicians. Thirty-four States have passed bills that restrict techniques that managed care plans can use to reduce the use of health services.

We must also develop a method by which access to care can be "taken" to consumers. Rather than waiting for health problems to develop (requiring a much greater cost to correct) we need to enlist a "health corp" program that decentralizes our clinic and hospital based system and moves it back into the neighborhoods of the community. By developing a easily accesses, streamlined administrative health system we can actually save money by helping people avoid illness.

In finding a solution to our growing health care crisis we need to consider a radical shift away from traditional paradigms of service and work to establish a model that is balanced between cost and access. New mechanisms of financing this system must be identified and put into place. As compassionate people we must find a way to provide care to those who need it. When the faces of the sick are not seen it is easy to cry out "it costs too much" but when the face is that of your father, mother, son or daughter can we turn away? These faces are in our future if we do not take steps now.