Health reform – lessons from the election

Social philosopher/author Norman O Brown and social biologist/author Edward O. Wilson eloquently describe the cornucopia and cyclic nature of human society. When my book," De-spamming Health – Reforming Health Care from the Bottom Up" was published in 2008, a few close friends opined the "cycle" was not right to attempt to change the prevailing health system reform paradigm. Lessons from the recent political elections suggest the cycle and paradigm have shifted.

The recent political paradigm had basic components – raise and spend a lot of money for a large staff of central "experts" to identify and target each "different" population group with a mass deployment of custom media messages and "ground games". This time it did not work because the cycle/paradigm had shifted and as futurist, Joel Barker, use to say, everything went back to zero.

Meanwhile, the victorious politicians spent a fraction of the money – and employed few central experts - primarily talking with the populations of diverse communities, seeking their opinions as to what needed to be fixed and how that should be done within their respective communities. They relentlessly reengaged these communities with the solutions they had crafted that each unique community could apply. What is the lesson for health care reform?

Long before passage of the Affordable Care Act (ACA), the health care paradigm had shifted about 50 years ago from an emphasis on local health care delivery (with back up from more centrally located specialists, epidemiologists and researchers) to the central financing and reimbursement of clinical health care and the central control of categorical grants to address specific public/population health issues. The ACA intensified this approach and essentially established a paradigm that a huge dollar and staff investment in central oversight administrators, auditors, accountants, quality experts and monitors would primarily control the system through how they reimbursed local health professionals and institutions. They, in turn, would contain health expenditures and improve health status, access and quality. How well has it worked?

Costs have skyrocketed, far beyond any marginal improvements in access or quality, while health status is essentially unchanged. Much of the cost is a reflection of the "non-valued added" expansion of "oversight" experts and monitors at the central level and the need for practicing health professionals to respond to such experts, often at the expense of diverting time from patient care. Especially in areas such as addiction and mental health services, access to necessary care is still grossly inadequate regardless of "coverage" status.

Tinkering with the health reimbursement system through interstate insurance competition and a few other ideas, e.g., drug pricing, may help address these concerns. However, significant positive changes will only occur when each local community is given the incentives, resources and authorities to significantly reengage in health care delivery. Health status (and to some degree costs) are over 80% a reflection of health behavior, genetics and environment. The

current paradigm of almost exclusively taxing local care professionals – who may have some impact upon 20% of health outcomes - with a complex, expensive and arcane system of penalties and rewards to improve health status and control costs is inane and wasteful.

Even more important, our local communities have little incentive and means to prioritize and address the duplication, low productivity, unmet access needs, poor life-style choices and preventable system waste that are present to varying degrees in each community. With a few exceptions, individuals are not taxed with a system of rewards and penalties to influence positive life-style changes. Locally, few communities assess the productivity of federal funded programs, content with the money and jobs they infuse within the community. There are few incentives for local practitioners and institutions to share resources and institute joint efforts to improve care access, comprehensiveness, continuity and reduce costs by combined reporting and other means.

The lessons I took from the election Is that our national health leaders need to talk more with the health professionals and citizens of each community and restructure central health programs and policies to provide communities with the incentives, resources and authorities to reform their health care delivery at the local level. The large staff and copious resources invested in central health policy and administrative experts need to be trimmed or redistributed to local communities. In each community the effectiveness and productivity of each program needs to be evaluated together with the "system" as a whole. The one size fits all philosophy needs revision. Communities need to determine the "ground game". That is how we win in the new paradigm.

Published in January 20, 2017 *Charleston Gazette-Mail* as "Health reform lessons from the election"