ACHA versus ACA debate – more garbage and aberrant focus

The Maslow "hammers" are again out in force looking for health insurance "nails". Ostensibly, the nation's health reform goals are to improve health status, access, quality, efficiency and cost-effectiveness for all Americans - but the hammers only see "health insurance" nails to pound.

Jonathan Gruber - the policy wonk who divulged that Obamacare claims about keeping one's health plan and doctor were knowingly false but sold to Americans because they knew the public was stupid - is back, claiming Obamacare was an enormous success until President Trump destroyed it after a few weeks in office. Many adversaries claim a bit of health insurance competition will fix things. They squabble, both far off the mark, believing new financing and reimbursement schemes will produce goal fulfillment.

The solution is enough money to reach our goals. That will never happen, even if we were willing to direct our total gross domestic product to the pursuit. Medical science will continue to offer amazing, costly diagnostic and therapeutic advances we will embrace. Ignoring the issue by insisting we change nothing and pour in more and more money from the "rich" is irresponsible.

Despite its best efforts the health system per se will have a marginal effect upon changing poor life style choices (e.g., substance abuse, violence, inactivity) that lead to preventable chronic disease, whose "down- stream" care costs suck up the major portion of our health resources. What is left is defining trade-offs and priorities. The questions are "who", "where" and "how".

There are two main options to promote our goals. The first is to cut - to the degree possible - the "non-valued added" administrative fat within the health care system. Promoting quality and accountability is legitimate but the costly, complex and onerous government and insurance company oversight of medical practice needs to be curbed. For instance, replacing insurance payments with "consumer cash" for a segment of the population (for routine clinical services) could save millions in low-dollar claim processing administrative costs. "Outlier" review versus "prior authorization" is another. These reforms must occur primarily at the federal and state government levels.

The other involves promoting system access, quality, and cost-effectiveness by reforming the health delivery system. We keep trying to accomplish this by various reimbursement, quality oversight and categorical grant programs initiated at the federal and state levels with little success. The problem is care is delivered locally and there are few incentives and mechanisms that exist locally to assure its quality, equitable "high priority" access and cost effectiveness. Duplication, low productivity and waste are widespread. Until the federal dollars are deposited at the local level to manage that is not going to change much.

Obamacare expanded Medicaid and it resulted in a few individuals gaining access to primary and limited secondary care. However, in many states it resulted in free clinics closing and a continuation of limited access for Medicaid recipients and others to mental health, addiction

and other services. Yet federal resources were poured into various community programs to prepare for the expansion. How much did this "insurance" fix really improve health delivery access in most communities? Not much.

Another example involves the inference by comedian Jimmy Kimmel - in his poignant piece about his newborn child with congenital heart disease - that if Obamacare was repealed 1,000s of newborns would die from this malady. I have been in the health field for over 50 years, long before Obamacare, and have never witnessed a child – insured or not – denied such care because of the network of children' hospital that exist to provide it.

In most cases lack of efficiency, access and quality in health delivery is not because of unconcerned or unethical providers but because the focus locally is upon individual institutions, not the community or system as a whole. Such mechanisms and incentives are few. Also, the decision are not simple or easy.

I refer you to the case of Clare and Dan Shirley from Cook County, Minnesota, chronicled by Casey Ross in a "STAT" April 17, 2017 newsletter article entitled "… A crisis in rural health care …". Clare had to travel several hours to deliver her second baby because a closer hospital (she wished to continue deliveries) stopped them for financial and safety concerns. This action created health safety and emotional concerns, and a harrowing experience, for her and Dan.

Health insurance is not mentioned because it had little to do with the health delivery dilemma, other than if the services had been continued it is likely everyone's premiums would rise. Which solution would be a "safer" choice for her and others is not clear. How much extra should the local system spend (and pass on to others) to accommodate her? Could she have been accommodated if tort liability concerns had been limited or assumed by others?

I could not reach a "right" decision. Every community experiences similar situations where the balance between "convenience" duplication, sharing, low productivity, safety, quality, access and cost –effectiveness is at play but unaddressed, resulting in avoidable costs. Obamacare and other reimbursement and financing programs do not and cannot impact such delivery. The AHCA does start to move some financial control back to the locus of health delivery but the mechanisms, incentives and authorities are not adequate. Until reform efforts focus on local health delivery, get ready for endless political theater.

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