Health status and care “under the bridge”

Recently, 15 state governors declared they do not want the flexibility to manage the health care funds their taxpayers send to Washington to assure a large segment of their state’s populations receive the care needed to maintain their` health status. They trust the federal government – largely through government health insurance interventions – will assure such health status. That shocked me as callous and cruel - instantly reminding me of examples of how much more determines health status – including my experience “under the bridge”.

About 40 years ago I went to Eagle Pass, Texas, which connects to Mexico by a bridge. Beneath the bridge was a tent city occupied by Native Americans, part of a recognized US tribe that resided in Oklahoma and a small reservation in Mexico about 50 miles from Eagle Pass. The tribal leaders in the village in Mexico, whom I visited, were concerned with the health status of their residents, especially pregnant mothers, children and others who primarily lived under the bridge to seek nearby employment opportunities and other amenities, returning to the village periodically.

This population - US citizens – were eligible for all benefits including Indian Health Service care and Medicaid benefits. Moreover, although there were no Indian Health Service clinics nearby there was a federally supported health center less than two blocks from the bridge. However, because of cultural factor, tribal members viewed the clinic as a “Hispanic clinic” and refused to use it. There were plenty of federal benefits and coverage accessible, just no acceptable care. What would have been your solution?

Tent cities exist today, especially for the homeless. A September 13, 2017 American Council on Science and Health article entitled *Homeless Camps Are Infectious Disease Time Bombs* notes the high incidence of infectious disease in such enclaves and raises the difficult and contentious ethical and policy discussion of what role communities should have in providing structured security for at least some of the residents, somewhat analogous to the old state hospitals. Some have raised the same issue regarding “care” for certain chronic narcotic addicts.

Closer to home, we have solo tents housing many seniors, who are far below the health status they could enjoy and often cost the health system dearly when they develop preventable serious injuries and illness. Much has been written about the large increase in foster care requirements as a result of the opiate epidemic wiping out the young adult population. That is the same population that often also helped care for senior parents. It has diminished and the resources to help with senior transportation, adequate nutrition, proper hygienic care and medication use, physical and mental activity are grossly inadequate and often fragmented in communities. Perhaps a few of the health dollars shipped to Washington could be redirected by a governor to address this need.

Even for those who do not rely on taxpayer supported federal insurance, and are relativity well off, often insurance is far from the answer. A September 5, 2017 JAMA article entitled *Effect of*

Colonoscopy Outreach vs Fecal Immunochemical Test Outreach on Colorectal Cancer Screening Completion is a great example. The article described the highly effective preventive screening tools available to the public to avoid death and debilitating and costly illness, including a painless, non-invasive, inexpensive test. They showed hard evidence of the great health status results for the 35% of individuals who took advantage of the screening. The problem is that despite repetitive, aggressive outreach, 65% did not get screened. If I lived in a community like this I hope my government leaders would take a few of the taxpayer dollars sent to Washington and get this screening number - and many more - up.

Every night I watch a TV ad where insurance companies, working with the federal government, display themselves as empathetic entities co-managing my personal health care with my physician. Other than for medical research and public health experts, I do not want or need that assistance. Spend it on health care instead of administrative bureaucracy and warm, fuzzy TV ads. Just pay the bill without hassle.

Recently, the Charleston Gazette – Mail featured a story about the abandoned Morris Memorial Hospital for Crippled Children property. I wondered what would happen if a "need" such that resulted in its construction in the 1930s arose today. Would the State and local communities rely on Washington to decide whether and how we should use the funds sent them by West Virginian federal taxpayers to address a major need in a community or the state as a whole?

Addressing important health care needs to maintain health status requires far more than assuring federal insurance for each individual. Federal funds are not infinite. I would hope most states would not only be willing but anxious to have the flexibility to decide how some of these funds could best be spent locally.

Published in November 5, 2017 *Charleston Gazette-Mail* as "Who wouldn't health care policy set close to home?"