Looking for health solutions in all the wrong places

How are we doing improving our Nation's health? Awful! Despite the application of amazing immunological, genetic and other advances, for the third year our life expectancy has declined while it continues to rise in other industrialized nations.

In the simplest terms, based upon outcomes, we are spending more (over 17% of our GDP) and getting less than other countries. Does that mean the clinical care components (doctors, hospitals, and insurance companies that accounts for about 20% of outcome) are providing too much unnecessary care for some and/or depriving others of needed care? Does it mean the care delivered is of substandard quality? Does it mean the administrative costs of care financing is exorbitant?

Not really. Although we can probably improve in all these categories, extensive analysis by Harvard's Ashish K. Jha, M.D., M.P.H., reveals quality, length of hospital stays, quantity of elective procedures, yearly per capita physician visits, insurance administration costs (whether public or private) and other clinical parameters show little difference between the United States and these other countries.

That does not mean there are not financial inequities and disparities resulting in some foregoing clinical care (especially drugs) but it is unlikely the major cause of our health status decline. Furthermore, resources directed at this 20% segment of outcome consume about 70% of the pot, limiting what is available to address inequities and other factors effecting 80% of outcome. The point is the overwhelming fixation with dumping more money into health insurance, public or private, is not going to do much to improve outcome. What is?

Keeping the population healthy and happy and controlling the price of clinical care (to free up resources to assist in this regard) are the solution. Early prevention and treatment of most health conditions, and healthy personal health practices, reduces much serious lifetime disease and disability, keeping most individuals happier, dying older and cheaper.

Substance abuse, elder abuse, preventable hospital readmissions and physician visits, avoidable frailty and traumatic injuries, obesity, violence, depression/ suicide, and non-adherence to treatment plans are a few factors driving life expectancy down and clinical costs up. Rising rates of vaccine preventable diseases, spread of HIV by positive individuals not receiving or refusing treatment, sub-optimal disease screening, rising sexually transmitted disease rates despite less sexual activity, denying opioids to elderly chronic pain patients because physician fear they will be punished for continuing to prescribe them are a few others

Many are influenced by various social determinants of health – adequate food, transport, housing, education, hygiene, social contact, activity, home assistance. Although "expert" outside consultative assistance may help, successfully addressing most of these issues requires a local community system and effort that in most localities is seriously deficient.

Local community and public health involvement must be drastically restructured and enhanced to improve the effectiveness and efficiency of health delivery and personal, preventive and environmental health practices. Rather than seriously study and correct this local deficiency, we attempt to address the issue through various wasteful, often unnecessary, fragmented central government, managed care company and health insurer "benefits" approaches and categorical grants.

Every other TV ad in the fall, pelts seniors to make sure to get their free rides, household aides, "silver slipper" fitness sessions, meals, and other benefits they allegedly "deserve' by signing up for certain Medicare plans through which the government will provide them.

Most of today's seniors are able themselves, or through family and friends, to provide these services. Meanwhile, many seniors who need them go without because they are unaffordable or unavailable or they have the wrong plan, or are unwilling or unable to ask for such assistance or nobody routinely checks on them. Only a local coordinated, comprehensive "system" can assure the seniors in need are contacted routinely and receive needed services. Why not use these government resources to build such community systems rather than for TV ads and an insurance plan model for the few.

The same is true regarding the horrendous price of clinical care. There is a role for central government and recent efforts to address the byzantine drug cost/price issue has shown some leveling of the cost spiral. However, the equally byzantine manner in which a non-transparent central government/ managed care/ insurance company/ hospital cabal determines hospital prices/charges remains elusive and hospitals and insurance companies are fighting to keep it that way. In the business section of the December 8, 2019 *Washington* Post, Steven Pearlstein, provides a detailed account of this hidden process.

Local communities have largely exited much of the health business and there is little involvement of the community at large to assure effectiveness and efficiency of hospital and other clinical services. That failure further deprives communities the resources to address the deficiencies noted.

Length prevents describing how the community could better address other issues. The simple point is that communities are unique and every health issue is not best addressed through central government directed insurance programs and categorical grants. We need a giant paradigm shift.