Health reform- Reversing the paradigm

Endless debates directed at improving the US health care system have become specious and boring, centered upon changing the way patient care is financed. “Medicare for All”, “single payer” and traditional insurance consume the vast majority of the discussion, devoid of any serious framework that examines the delivery system and associated costs, effectiveness and efficiency. Financial analysis in a vacuum is largely useless and logically backwards.

A few have questioned the wisdom of the current approach. Megan McArdle in an October 18, 2019 article in the Washington Post challenged presidential contenders to begin by examining the “delivery” of health care before consideration of financing - relating various examples of the differences in the effectiveness and efficiency of care delivery. It was a good start but failed to go far enough considering the vast differences in communities, especially rural, and the role of deficiencies in basic public and community health services.

If you believe health care expenditures, as a percentage of the GDP, can continue to grow indefinitely, read no more. However, for those who realize technological advancements, sub-optimal prevention and health behavior, and system inefficiencies contribute to a level of health care expenditures that is unsustainable, read on. Prevention and early primary care interventions – delivered efficiently - can result in multifold savings downstream. Telemedicine and AI - if prudently applied within community systems – could assist.

The New York Times recently explored the desperate health care situations in many Native American communities suggesting tribes take over care delivery from the Indian Health Service (IHS). There is little explanation as to why they believe the results will be any different than the plight being faced by many rural communities who continue to lose health facilities and health professionals to provide preventive and early primary care. When the health professional management of the IHS began to be dismantled in the 1980s, it became even more difficult to maintain adequate staffing and accredited facilities in many locations, although there are some examples of tribal success. Each setting is different.

Gross surveillance of the health of the US population has recently recorded some puzzling concerns. While the frequency of sexual relations have significantly declined in adolescents and young adults, the incidence and prevalence of venereal diseases (STDs) have skyrocketed. The same is true of certain health conditions in middle age males. Elderly patients have never had better access to clinical care but are suffering “at home” accidents and other preventable conditions leading to further morbidity, hospital readmissions and disability. Many of these involve communication deficiencies and the failure of communities to address even the most basic social determinants of health through adequate education, surveillance and intervention within the home setting.

The etiology of these concerns is complex and multi-faceted, however, with the expansion of Medicaid and other assistance programs, it is doubtful changing care financing will make a

significant difference. We face enormous challenges in basic health delivery including education and public, community and home health.

McArdle addresses the “efficiency” issue by citing a model that works in a mainly urban setting. There are also some successful rural models, although the rural setting is a much greater challenge. The principle to remember is that each setting is unique. Efficiency can be found in many places.

Ashley Furniture has made an interesting arrangement to reduce costs. They contract with a hospital in Cancun, Mexico, supplementing its quality and communication capacity. They voluntarily fly and board patients and surgeons to perform certain elective surgery. The cost savings are 30% or more, including a cash bonus, instead of a co-pay, for the patients. Although there is the propensity for quality and communication concerns, patients are pleased with the care. It is difficult to believe that facilities in the US could not be designed to significantly cut costs to at least match such care and costs.

Until we seriously analyze these issues and define the minimum care access for each unique community, we will have no idea what it will costs, the frameworks essential in each setting and the best financing mechanisms. Insurance coverage may be the least of our worries if improved health status is our goal.

Published in October 26, 2019 Charleston Gazette-Mail as “Reversing the paradigm on health care talks”