

Short Book Review:

Critical - What We Can Do About The Health-Care Crisis – Senator Tom Daschle et. al.

Daschle's book presents many interesting health related statistics, observations, and stories. It also leaves out, leaves out of context, or downplays many others. As I will discuss later, it is never clear at a point in time what "system" or "systems" Daschle wants to reform and/or his *specific* "system reform" goals. By failing to identify specific loci of responsibility for clearly identified systems – and assigning measurable performance goals to each – Daschle perpetuates the fantasy that the "amorphous we" can have it all if (through him) given the power to slay various, vaguely defined, health professional and institutional ogres, i.e., the "amorphous they" enemies, that prevent this from happening.

Although Daschle pays lip service to the assertion that providing or purchasing health care is not the same as obtaining television sets, he demonstrates minimal knowledge of the dimensions of that difference. He shows little understanding or appreciation of the complex task in the real world of melding social, cultural, economic, genetic, environmental, geographic, and a slew of other influences to assist each unique individual and community determine what is the best treatment or health care course of action to maintain or enhance health status. Daschle best illustrates this by proposing a new national entity to engage in expanded cost-effective research so as to assure provision of only the most cost-effective drugs and treatments whereas the reality is that the nation (especially central government insurers) lacks the capacity, will or resolve to apply the currently available results of such research.

Daschle dismisses as "myth" (invidiously spread by "misinformation" and "stoking fear") the notion that there may be anything good or valuable about US healthcare. A barrage of selective stories and statistics accomplish this, concluding it is inferior in every aspect according to various "ranking" indicators. One would like to see the worldwide preference "ranking" indicators of US developed drugs, devices and procedures, as well as where individuals throughout the world – cost aside - would elect to receive their life saving care and procedures. He also downplays the issue of how Americans would react to overt rationing, e.g., Avastin, dialysis, knee/hip replacements, as employed by other countries.

I could go on about how little Daschle understands health care delivery and that far more than health insurance coverage and cost-effectiveness research influence it. However, I will focus upon the paramount weakness of the book – the assertion that repackaging and reinventing the failed centralized approaches of the last 50 years (through establishment of a "National Health Board") will successfully reform the system. The irony is that I agree with most of "what" he proposes to fix but believe he is way off the mark regarding "who" should fix it, "where" and "how".

In my 40 years of experience at nearly every health system level, I have seen a myriad of well-intentioned central government proposals, policies, and programs enacted to reform

the system. Some have had a modicum of success. Most have failed or resulted in increased costs and “unintended consequences” that often far exceeded any benefit. I am not convinced that central government further tinkering with central health financing, insurance, funding, and applied “cost-effectiveness” research functions will accomplish successful system reform (e.g., improved health status and health care delivery, access, quality, effectiveness, and efficiency).

In recent history, improved delivery models, e.g., HMOs, PPOS, managed care, medical homes, and quality initiatives, e.g., PSRO, PRO, P4P, PQRI are the most discussed “system reform” examples spurred by central initiatives. A common pattern emerges. Patients, practitioners, and institutions quickly learn how to “game the system” to achieve maximum benefit, some legitimate and some not. The central authority institutes more central action to correct the “gaming” problems; this, in turn, usually results in more gaming, cost and unintended consequences. Often the initiatives become so costly, convoluted, and cumbersome the central authority scraps them and introduces new “reinvented” versions.

The notion that central government - by tinkering with funding, cost-effectiveness research, and reimbursement policy - can influence the successful operation and reform of complex health care systems where most exist – the local community or “medical trade area” - perseveres. The folks at the local level collectively lack the authority, flexibility, mechanisms and, most importantly, incentives to set priorities, assess tradeoffs, control costs, hold individuals, practitioners and institutions accountable, promote integration and efficiency, etc. So individual patients, practitioners, and institutions continue to game the system rather than reform it. Medicare is a great example with its widespread variations in costs of care to achieve the same results within different geographic regions and overutilization of services and equipments, e.g., scooters, home health, HIV care, bordering upon, or constituting, fraud.

The book insinuates many “apple pie and motherhood” *inference* reform goals. These include goals whereby no American suffers financial ruin because of unanticipated catastrophic medical events and that no American foregoes the opportunity to live a longer, happier, healthier life free of disease and disability because he or she cannot obtain essential care solely because of one’s economic circumstances. The book suggests a goal of improving the effectiveness and efficiency of health care delivery and administration to free up resources to address financial barriers as noted above and better allow US companies to compete globally. In addition, probably, the insinuated goals include improving the health status of the population. There are other goals inferred, e.g., increased quality, fewer deaths and disability because of preventable system errors, and enhanced prevention. There is no delineation of the system or systems responsible for addressing each such goal and any specific measurable outcomes. The inference is that the “amorphous we” is the loci of responsibility for achieving it all.

Few would disagree with such broad goals, including the long list of enemies, various vaguely defined health professional and institutional groups and obstructionists, i.e., the “amorphous they”, Daschle claims have fought passionately to prevent the Nation from

achieving these goals. He largely attributes such failure to the ignorance, inertia, base greed, and ignoble intent on the part of this long list of enemies. He further avers that the solution is obvious, a high-tech media blitz and more central government controls and authorities to silence, prod, change, or neutralize the enemies he indicts at any point in time. He seldom presents a solution while simultaneously and comprehensively addressing the integration, interrelationship, and interdependence of all desirable goals within a “real” health system.

Daschle never concedes that the motives of many of these “enemies” might possess a modicum of altruistic merit – and that they often might identify legitimate tradeoffs and consequences the public may wish to avoid. By minimizing – or failing to mention – many of these consequences, as well as ignoring other factors that contribute significantly to many current health system “problems”, his analysis is deficient and suspect. A few of these missing (or downplayed) factors include:

- Social and cultural beliefs, as well as escalating and widespread abusive and unhealthy behavior, – largely beyond the control of the health care system - often trump healthy life style practices and the receipt of recommended care
- Cost-shifting and system insolvency due to failure of central government programs to reimburse fairly and adequately because of their overall “fiscal constraints”
- Failure to rein in an out of control tort liability systems and the corresponding cost of “defensive medicine”
- Unwillingness or inability of *existing* central government quasi independent scientific and reimbursement entities to set “limits” despite convincing scientific evidence of poor cost-effectiveness and/or the futility of certain care.
- Failure of the *public* to support adequately the implementation of horizontally integrated community health information networks, including electronic patient medical records.
- Inevitability of a two tier health care system within a free, capitalistic, democracy since individuals with monetary resources will always be able to obtain the care they desire, e.g., from off-shore entities, regardless of the decisions of any national board or entity.

These are but a few of the “other” influencing factors and deficiencies confronting the current health care system.

Daschle throws a plethora of selective historical and contemporary facts and observations at the blackboard upon which he has written his solution, with the intent that enough of these will stick such that the public will be convinced he has the answer. He employs poignant examples of personal catastrophes to infer that the majority of the “class” he is discussing at a point in time suffers from the same calamity, to the same degree and for the same reasons. The actual percentages and possible other contributing causative factors are usually absent. His stories and examples themselves often invite possible contradiction and convoluted logic.

My favorite involves a story of a man with back pain who dangerously overdoses himself with painkillers because he cannot afford back surgery. The inference is that in the case

of this man – and the thousands one should assume are in the same class – back surgery would result in cost savings and greatly improve functional performance, quality of life, and economic growth. Yet, elsewhere he indicts physicians and others in the health industry for using many expensive drugs and interventions to advance their own best interests rather than the patient's or public's. The irony is that while over the last few decades the spending on care for back pain, especially surgery, has continued to markedly escalate, the actual pain relief and functional performance of back pain sufferers has declined. Statistically – and based upon cost-effectiveness analysis – the fellow Daschle mentions and public is probably better off without financial access to the expensive surgery that will drive up health care costs with few anticipated health status and economic gains.

The discussion of emergency room care is another case in point. Daschle contends that Americans, because they are uninsured or underinsured, fail to obtain critical preventive and primary care and eventually end up in the emergency room with far advanced costly disease and preventable morbidity. He is correct that such care is inappropriate, e.g., poor continuity and excessively expensive. However, the genesis of the problem is much more complicated than a lack of health insurance coverage. Recent studies show the recent increase in the use of emergency room care is largely the result of an increasing number of *insured* patients using such facilities because of a lack of availability of a reliable source of appropriate “24-7” primary care in many communities. This problem is at least partially attributable to a shortage of primary care physicians and the failure – and lack of incentives – for local communities to institute “organizational” changes to assure such “24-7” access. Moreover, in cases like Massachusetts cited by Daschle – which significantly increased health insurance coverage - the emergency room and cost crises have intensified, not diminished.

By largely omitting, downplaying, and ignoring many important factors that influence health system performance and success, i.e., enhanced health status, Daschle intends to convince the reader through a sophisticated media initiative that he has all the answers and they are obvious. In fact, he contributes to further polarization in lieu of solution. Moreover, he inadvertently but callously dismisses and discourages the merit of numerous State and local initiatives that hold promise for real reform.

Copyright Notice – Copyright 2009 James D. Felsen, MD