

Health reform bill will not contain costs - the solution (Part 2)

Probably the greatest opportunity for elevating the public's health status and saving resources centers on a group of individuals who participate in the health system only when they are acutely ill or injured. Some opt not to participate by choice for many reasons. Others fail to do so because of barriers beyond their control.

The end result is usually reduced health status and increased costs for these individuals or society, probably partially avoidable if they had altered their life-style behaviors and received recommended services in a timely manner. This group represents the greatest challenge to society but we have elected to ignore many aspects of this challenge.

Proposed health reform legislation greatly assists, entices or compels every American to participate in the health care system. To the extent that individuals personally are actively involved in promoting their health status - but truly lack the financial means to obtain certain recommended health services in a timely manner- guaranteed financial access (assuming there are adequate medical resources available) should have a positive impact on maintaining health status and, possibly, saving money. We have little idea what percentage of folks fall into this category. Most estimates are based upon interview surveys, which are notoriously inaccurate.

However, there is a proportion of this group (probably well over 50%) who fail to adopt recommended life-style practices and receive recommended care in a timely manner because of factors other than financial access, but for whom society at large, rather than each individual, now will assume responsibility for health status and cost consequences. One can hardly hold physicians responsible for the outcomes. Physicians could repeatedly discharge such patients from their care but this will accomplish little as regards the taxpayers' investment to enhance health status and contain costs.

Recently there have been considerable activities, e.g., "medical home", EHRs, to improve the organization, coordination, and automation of medical practice to assure patients receive the most cost-effective care in a timely manner. However, we largely have not addressed the roles and responsibilities of patients and the public when the responsibility for outcomes has essentially been ceded to the public.

The greatest gains possibly could be realized by *locally* identifying and tracking those currently usually *not part* of the health care system and offering them incentives to adopt practices and utilize services that have the potential for improving health status and containing costs. Local authorities, mechanisms and incentives to do so are largely absent. Of course, there are legitimate privacy and ethical concerns, but should taxpayers "carte blanche" assume

responsibility for individuals who cannot or will not act responsibly? At what point, does society, with the help of the physician, discharge the patient?

Most of us, without guilt or regret, could consume far more goods and services than we do. Most would not fight an entitlement that would help us to do so. Likewise, many of us would probably exert less effort to maintain various personal and household items if someone else would suffer the cost of our neglect. What goods and services get consumed – and what effort is directed at maintenance – largely depends upon operation of a “choice” mechanism that considers the amount of available fixed resources, goals and the most important expenditures to realize those goals.

Individuals have been making such choices for years. This pattern is also true for some organized groups and communities. I am personally familiar with two health “groups”, Indian Health Service and West Virginia HealthRight, which have done so. There are others.

HealthRight, among other measures, places individuals who smoke and refuse to avail themselves of certain available health screening services into a lower priority level for dental services. One of the rationales is simple, pure cost-benefit. Such individuals are less likely to heal and more likely to experience cancer before they can enjoy the full benefits of the dental procedures than those who do not smoke and receive screenings. They have been denied grant funds and criticized for such practices.

Faced with a fixed amount of resources, choices must be made. This means a worthy individual and/or service (individual or community) must be denied because it has been determined a “more worthy” individual or service exists that will produce more health status gains. It is called rationing, a practice no group likes to exercise and one that is guaranteed to invite criticism and disagreement, not only over the practice per se but choice of criteria employed. Of course there is no need to ration as long as society (as with the current legislation) is willing to set no expenditure limits or until expenditure consume 100% of GDP.

When individuals are no longer responsible for the consequences of their choices, cost-containment can only be realized when some other entity is provided a fixed amount of resources and empowered to determine the priorities for service provision (who and what) based upon an established goal, i.e., maximum health status gain. We have yet to begin.

Copyright Notice – Copyright 2009 James D. Felsen, MD