

The Myth of Health Financing Reform—The Need for Local Health System Reform

Health “financing” reform, universal coverage, single-payer, medical savings accounts, or “whatever,” will not fix the problems with today’s health care system. Such reform might mitigate certain access and equity concerns but, in fact, could accentuate many current vexing deficiencies unless accompanied by meaningful local community health delivery “system” reform. This reform will occur only when local communities regain ownership of their health care systems and drive the agenda from below.

Most Americans love the sophistication and scientific quality of the health care they currently receive. It allows them to obtain preventive services, such as immunizations, prophylactic medications, and adopt health behaviors (e.g., diet, exercise) to avoid the morbidity, disability, and mortality many would have suffered 50–100 years ago. It lets them enjoy longer and more productive lives free of serious disability. In certain cases, it restores body systems that have degenerated to a functional level enjoyed as a young adult.

Most Americans hate the health care systems. They decry its confusion, complexity, and fragmentation resulting in frequent miscommunication and glitches in coordination and continuity of care services. They dislike its high cost and the financial, geographic, and cultural inequity of access suffered by many. Its failure to arrest the increasing disease, disability, and death associated with antisocial and poor health behaviors (e.g., childhood obesity and

diabetes, substance abuse, violence) frustrates them.

Pouring more money into the health care system, realigning reimbursement mechanisms for health care practitioners and institutions, and redistributing payment responsibility among the public and private sectors are legitimate social and political issues worthy of debate. Some argue that administrative cost savings might result. In addition, as noted, such changes could promote financial equity of access. This could assist some individuals to obtain preventive and timely primary care services, thus avoiding more costly emergency room and hospital care. However, “Healthy People – 2010” and other studies reveal that a minority of the public optimally affords itself of many proven effective preventive interventions even if they enjoy financial access to health care. There is no reason to believe the currently uninsured will be any different.

Alone, financing changes will have a marginal impact upon controlling costs or addressing the other deficiencies noted. These deficiencies are the product of a delivery system that is often fraught with waste, duplication, inefficient, and ineffective interventions and the failure of many individuals to assume responsibility for their health. Moreover, whether through paycheck deductions or government taxes, increasing the amount of resources directed to pay for health care places the country at an economic disadvantage within a competitive global economy.

As many have noted, the problem with health care is that we want to consume more of a good thing than we can afford. Put somewhat differently, we debate forever whether we need to move the boulder a little to the right or the left of the road when the problem is the size of

the boulder. Unless we can find ways to reduce ineffective interventions, waste, and duplication; promote efficiency; and entice more people to assume responsibility for their health status, the size of the boulder will continue to increase. The size of the boulder can also be limited by decreasing the quality, access, coordination, and acceptability of care services, but few find these options acceptable. I will examine a few examples.

Each day thousands of disoriented, minimally responsive, incontinent, elderly folks—with far-advanced multiple system disease and no chance of regaining any functional improvement in the quality of their lives—are roused from their nursing home beds and taken by ambulance via wheelchair or gurney to dialysis centers. The pain, discomfort, humiliation, and indignity many of these folks experience—being jostled, often poorly dressed and groomed, and exposed to extreme heat and cold, during transport — are not hard to imagine. When they arrive to have their lives extended artificially, they experience further jostling, jabbing, and the distressing symptoms (e.g., vomiting, dizziness, headache) often associated with the highs and lows of adjusting fluid and electrolyte balance. This occurs three times each week, often for a year or more, at a tremendous cost to both the individual and society.

Ineffective “end of life” care—including that which extends by artificial means the lives of barely responsive or unresponsive individuals with no chance of improving their functional status or quality of life—contributes significantly to the size of the boulder. Such costs are not primarily the result of ineffective care provided by medical professionals and institutions per se but are the consequence of communities’ inability or unwillingness to address complex, often

controversial, moral, ethical, cultural, economic, and political issues.

However, there are other examples of ineffective and inefficient care that should be less controversial. For instance, rapid treatment of stroke victims with clot-busting drugs in emergency rooms can prevent a large portion of the morbidity and disability (e.g., paralysis, weakness, speech loss) associated with stroke. Not only would this allow people to maintain the functional quality of their lives but also would carve a big chunk out of the boulder. The cost of rehabilitation and support services for those who survive a stroke are enormous.

Yet few people who suffer a stroke receive such care in a timely manner. Why is this? There are several reasons. Some involve the failure of victims, their families, emergency personnel including 911 dispatchers, and medical professionals to recognize the symptoms and signs of stroke early enough and to expedite treatment. Others involve the unwillingness or failure of medical personnel in emergency rooms (for medical liability and other reasons) to promptly institute treatment without having more medical information about the patients. This mainly involves knowledge of whether the patient has any history or risk of bleeding, even though only a small percentage of strokes are caused by bleeding as opposed to clots. The costs to fix these effectiveness and efficiency problems involve patient, public, and health care personnel education; certain liability reforms; and the institution of electronic health record systems. These fixes are inexpensive compared to the rehabilitation and associated costs of caring for stroke victims.

Most physicians know that individuals who suffer serious thrombotic cardiac events (or the proclivity to develop

them) can significantly reduce the probability, and associated costs, of future such events, including stroke, by using certain preventive therapies, e.g., aspirin, thrombolytic agents, and life style changes. However, many insurance programs inadequately cover the cost of educational, patient management and related life-style promotional activities proven effective in reducing the sequelae and avoidable costs of this condition and many other chronic diseases, such as diabetes and hypertension. Local communities could help assure insurance programs reimburse for such effective ancillary services or provide them directly as community/public health services.

The failure to institute broadly electronic health records and other integrative mechanisms among all health professionals and institutions within a community contributes to significant waste and duplication as well suboptimal quality and continuity of care. Performing dangerous treatment procedures and prescribing contraindicated medications can result from the failure to have complete medical history information available or to be “prompted” as to potential dangers, such as drug interactions. The cost of unnecessarily repeating recently performed laboratory and imaging tests because the results are not readily available is significant. The failure to have such systems available to enhance communication among professionals, and to cull the most important data from voluminous medical records, in order to “prompt” a professional to address critical issues (e.g., failed referrals or follow-up, abnormal test findings) results in avoidable and costly morbidity. These are but a few examples. The technology and mechanisms to promote such communication and functionality, used within other sectors for over 20 years, are relatively cheap when compared to

the consequences of the failure to employ them.

The cost to communities of multiple institutions installing expensive but underused diagnostic and therapeutic equipment is considerable. Yet “certificate of needs” programs to address this concern have been largely unsuccessful. Why is this?

It really is quite simple. The citizens of local communities experience no direct, tangible negative consequences of such practices, although they, and all of us, suffer increased health care costs as a result. However, within the local community the only direct consequences are positive: increased availability, quality, and access of care. The increased health care costs are too indirect and remote a consequence to prompt action by the community to promote the efficient use of such equipment. Below is an example of the dynamic at play.

Each year the various departments of local government (e.g., public works, public safety) update and replace equipment such as fire trucks, ambulances, snow plows, school buses, radios, and police cruisers, which are essential for them to perform their missions. Seldom does every department receive what they claim they need to function optimally. The limiting factor is the budget of the community and the tax revenues that influences it. The community makes choices and accepts the consequences of those choices, good and bad.

Suppose each local community department head submitted their equipment requests—with the endorsement of local community government officials—to state or national entities for funding. The cost to society to fund all such requests in this manner is no different than funding them

locally. However, the negative consequences of such a choice (i.e., increased fees or taxes) are much more indirect and intangible. Thus, most local community governments would endorse and advocate for full funding although the consequences would be higher taxes and fees for all citizens. In this scenario, the only tangible consequences of full funding that local governmental officials and citizens envision and weigh are more availability, quality, and access of services. This is unlikely to change within the health care sector until local officials and citizens have to face directly the negative consequences of the underutilization of expensive equipment such as increased health insurance premiums, inability to fund other higher priority needs, or higher local taxes or fees.

A similar dynamic greatly influences the community health sector because a large portion of local funding flows from state and federal sources. The intent of community or public health activities is to provide surveillance and monitoring of environmental and related hazards affecting a population as well as the health status of the population per se. Based upon the findings of such activities, in turn, communities initiate various environmental and health-related protection, abatement, educational, screening, promotional, treatment, and tracking interventions to reduce hazards and maintain/elevate the health status of the population.

Within the community public health arena, waste, duplication, inefficiency, and ineffective initiatives are rampant. Why is this? It primarily relates to the fact that most communities are unable or unwilling to conduct adequately the surveillance and monitoring noted and, as importantly, select, prioritize, and institute the interventions that are most likely to influence positively the health status of their respective populations.

Instead, a number of higher-level governmental and private advocacy and philanthropic agencies, foundations, and institutions, usually well intentioned, select and prioritize the interventions for all communities. Whether through charity donations or taxes, the citizens of local communities provide a large share of the resources distributed by these entities but have little direct say in their distribution. The result is a plethora of categorical intervention initiatives that may or may not address the most critical concerns of the community. Contributing to this problem is that few communities have collective decision-making structures and processes in place to prioritize their public health concerns.

The result is that often many communities operate multiple categorical programs to address relatively low priority concerns while failing to address—or address effectively—other higher priority concerns. Thus, many individual communities reduce the collective effectiveness of their total public health efforts.

The initiatives selected for funding often reflect the interest of some celebrity, scientist, or politician, fueled by the efforts of public relation firms and the frenzied feeding of the press, more than they do priorities selected through needs-based analysis. Recently, we have experienced the “year of the anthrax,” “year of the West Nile Fever,” “year of the smallpox,” and currently the “year of the “pandemic flu.” Ironically, I remember discussing with the public, press, and politicians in past years the relative level of effort I believed these various initiatives deserved. I often would mention that, based upon my judgment, pandemic flu was a much higher concern upon which the public should concentrate resources rather than these other threats. Pandemic flu

was just as big a threat from 2000–2004 as during 2005–2006. I am pleased with the attention it is getting but in my opinion, from a need's-based perspective, the level of effort it deserved (as compared to these other threats) was as great several years ago as today, yet it remained in the shadows. Furthermore, there is little reason for me to believe that smallpox is any less of a threat today than it was in 2002–2003 when it consumed what I believe was an unjustifiable amount of attention and public health resources.

At least to a degree the findings and trends of global disease surveillance theoretically influence the relative level of effort affecting various infectious disease control efforts. However, the same “disease of the year” pattern and process occurs with other interventions addressing various acute and chronic diseases and health risks. This is in lieu of prioritized applications based upon a community-by-community needs assessment.

A rational, community-based, needs assessment process likely would help to improve the collective effectiveness of a community's public health effort. However, per se it will not address the waste, inefficiency, and duplication concerns. Almost every moderate-size community (100,000–200,000 population), I would estimate conservatively, has in operation over 100–200 separate categorical community public health programs. These range from public clinics for immunizations and the treatment of tuberculosis and venereal disease to various public and private educational, advocacy, and support efforts addressing nearly every health risk, disease, and condition (e.g., pregnancy, high-risk infants, colostomy care, smoking and tobacco control, epilepsy, home health care, alcoholism, gambling addiction, multiple sclerosis, breast

cancer, and domestic violence and abuse).

Some of these efforts primarily represent the product and efforts of local citizen volunteers who join to address a common concern. They perform exemplary service with minimal administrative expense.

However, other efforts represent categorical initiatives instituted publicly or privately at higher levels with the stipulation that the community initiates a prescribed program as a condition of receiving health resources. I have discussed the effectiveness concerns associated with such an approach above. However, there are other problems with this approach. Most often, each such initiative establishes its own separate administrative and programmatic structures and reporting requirements at the national/federal, state, and local levels. By the time, these structures are paid for, and the reporting requirements fulfilled, often little staff time or resources are left to provide actual community services. Furthermore, such new initiatives, that often differ little from ones already operating within the community, arrive but each incurs the overhead expense of its separate operation. As a small example, I once received fliers from two different institutions offering smoking cessation training for physicians at the same location about one week apart.

A community is limited in its ability to control private initiatives but it certainly can use its collective influence to try to convince these various programs to direct their resources towards the highest priority concerns of the community and meld their operations with similar entities to reduce administrative costs.

However, a great number of community health programs receive funding directly

or indirectly — in whole or in part — through public resources. In the public arena a community, especially if it joins in advocacy efforts with other communities, should have much more influence. They can advocate that rather than be compelled to continue to conduct multiple, marginally effective programs in every categorical area (especially those the community has determined are low priority or directed at needs already being addressed by other programs) communities be able to redirect categorical resources to address more effectively their highest-priority unmet needs. Communities can also advocate that publicly funded categorical programs use a combined program review and activity reporting mechanism as well as a unified budgeting and cost-accounting system. Currently considerable resources are wasted operating separate program and administrative accountability systems for each categorical program. This contributes to the mass of the boulder.

Often the funding for many small, relatively ineffective, and inefficient categorical programs continues for years with little change in the mandated outcomes. Why is this? It involves the interplay of what I refer to as “unfunded mandates” and “accountability accommodation.”

The funding source mandates the activity, service, and health status outcomes required by the recipient as a condition of accepting the funding. Both the funding source (including its intermediate agents) and the recipients know it is impossible or unlikely the funding provided will result in the accomplishment of the mandated objectives, although both strongly endorse the intent. Nevertheless, the funding source provides the agency funding year after year. The recipients of the funds, and the intermediate agents, repeatedly report to funding sources the

structures and process that the recipient initiated or maintained in order to be able to address the mandates, but not the accomplishment of the mandated services or outcomes per se.

Such ongoing “accountability accommodation” allows the funding to continue such that politicians, foundation boards, donors, and the public do not have to be told, or acknowledge, the programs as structured are not accomplishing their objectives. In addition, communities often use such funding to provide employment and support the provision of basic health services to a segment of the population. Discontinuing it would negatively affect such a provision and result in various political and other consequences. The downside of such “unfunded mandates” and “accountability accommodation,” is that communities have little incentive to channel more effectively and efficiently the resources of these programs to have an actual opportunity to accomplish the mutually desirable outcome objectives.

Finally, there is the issue of citizens assuming more responsibility for maintaining and enhancing health status and the prudent consumption of health services. Certain health financing related incentives (e.g., health savings accounts, increased insurance premiums for smokers, penalties for seeking care in costly venues) could likely positively influence behavior in this regard. However, with a few exceptions, to date primarily only relatively affluent and privately insured populations are adopting these initiatives on a limited basis because of political and other reasons. Citizens who rely upon public funding to support their consumption of health services have few apparent direct incentives to embrace such initiatives. I applaud these efforts but am not optimistic there will be wider adoption within the public sector until local

communities use peer pressure and other sanctions to encourage increased personal responsibility and accountability.

I am not intending to raise the “welfare Cadillac” flag but have personally witnessed practices that are frustrating to say the least. One of my favorite scenarios involves the number of times I have followed male smokers in the grocery store checkout line who have separated their food stamp eligible items from the cartons of cigarettes they purchase by cash. Some of these individuals suffer from respiratory insufficiency and erectile dysfunction, both negatively affected by cigarette smoking. Yet these smokers will seek and receive inhalers and erectile dysfunction medications at public expense to assist their performance although they have the resources to purchase cigarettes that are impeding such performance.

This is just one small example of individuals who take resources from their neighbors to treat medical conditions that they are doing nothing to positively impact by modifying their health behavior or who are in fact spending their own limited resources to make the conditions worse.

More importantly, even among citizens with public or private economic access to health care services, only a small minority fully embrace proven effective preventive and lifestyle behaviors and practices. Substance abuse, violence, obesity, poor dietary practices, inactivity, and so on are not primarily the result of financial access to health services. With a few exceptions, the culture, ethos, and behavior of those with whom we associate most influences such behavior and practices. This in turn takes one back to the local community and its willingness, capability, and flexibility to address such concerns. As noted

above, that capacity is often decreasing rather than increasing at the local community level.

Nothing currently prevents a community from forming a deliberative mechanism, including health care practitioners, institutional representatives, philanthropists, politicians, and citizen representatives, to assess and prioritize the community’s health care needs. Such a group could promote internal (i.e., community-wide, organizational, management, and integrative) process adjustments to improve the effectiveness and efficiency of health care delivery, especially for the marginalized and disenfranchised.

It could also develop an external political action agenda, joining with other local jurisdictions, to advocate for the elimination of unfunded mandates and greater local flexibility in the use of state and federally provided categorical resources. It could suggest diverting certain categorical “health” funds to address underlying socio-cultural, educational, and related issue that contribute to health morbidity. Current rigidity in this regard, exercised by higher-level governmental and special interest entities, hinders a community’s ability to use categorical resources most prudently. The nation’s governors are beginning to weigh in on this matter and there is no reason local communities should not follow suit.

If a community successfully demonstrates the interest, capability, and resolve to take such “baby steps” to begin to improve local health system performance and efficiency, it would be in a position to demand greater responsibility for defining priorities for the much more difficult arena of clinical patient care delivery. These determinations often involve complex moral, ethical, cultural, economic, and political issues as noted such as how

much a community should spend on terminal care for minimally responsive individuals incapable of improving the quality of their lives.

A local community could convey to every citizen (and the health-financing group that represented each) *expected* healthy lifestyle and prudent consumption of health services practices. It could suggest to payers of health care the minimal services (scope, nature, volume, intensity) they should cover within the community. Based upon an analysis of the most efficient manner for delivery of specified “minimum” services, the community could define a fair market price per unit of health service. The payer (or citizen) would pay a premium if the group they represented failed to meet the expected lifestyle and prudent consumption practices.

The groups represented by government payers would pay the same community-determined per service fair market price, and assure the same healthy lifestyle and prudent consumption practices by its members as any other group, or pay for the difference. Only under such conditions is it valid to conclude a “prudent purchaser” exists and there is no government “cost shifting.”

With a few exceptions, such as the military, the only health systems we have are local. Yet few health-financing proposals address correcting current “system” deficiencies through local health care system reform. Few local deliberative entities are in place to assess local health system effectiveness and efficiency; cull waste and duplication; promote communication, coordination, and continuity; and set priorities for the use of limited resources. In addition, as mentioned, such bodies could apprise citizens (and create positive and negative sanctions and initiatives) of their responsibility to maintain and

improve their health status and purchase health services prudently.

Individual citizens and patients, health care practitioners and institutions, and the public at large, through its political, social, economic, and philanthropic institutions, all have a stake in limiting the size of the boulder. Yet they have ceded such responsibility to an amorphous “they” that is incapable of addressing their local community delivery system as a whole. “They” tinker with fragments or components, which may help or hinder the overall local system effectiveness, efficiency, and quality, while the locals sit back impotently, failing to “weigh in.” Unless any health financing reform measure meaningfully addresses local community deficiencies, the result will be more promises and fewer products, that is, little delivery system improvement.

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