

State and federal health system reform – a study in contrast.

I congratulate the Legislature and Governor (Senate Bill 414) for their leadership to institute meaningful health system reform. As a frequent critic of past efforts, such applause does not come lightly. This modest first step – launched without massively expanded regulatory authorities and expenditures – could hold great promise to realign positively the structures and processes of health care delivery systems where they exist – local communities. This effort is in stark contrast to the circus underway 300 miles east, where the national system reform effort consists of a high tech, expensive media blitz to justify massive new centralized spending, insurance coverage, and regulatory authority activities. These - purposely vaguely described - activities allegedly will assure tremendous cost-savings and health status gains.

I could quibble with certain aspects of the State legislation, e.g., too much emphasis on State versus local authorities, mechanisms, and incentives; preoccupation with the mechanics versus concepts of a medical home. However, this effort embraced meaningful deliberation by a broad, grassroots' segment of the population to develop an approach to address substantive organizational and behavioral health system issues and barriers contributing to substandard health status and skyrocketing costs. Implementation will not be easy and there is no guarantee of success.

Nationally, after years of struggle to reach a consensus on how to best reform the system to enhance the population's health status - without bankrupting the nation and diminishing the current access, quality, and sophistication enjoyed by many Americans - such a consensus allegedly has surfaced. Groups such as "Health Reform Dialogue" have published the "solution" endorsed by a wide array of diverse medical, business, social advocacy (e.g., AARP), civic, health, pharmaceutical, and insurance groups. Politicians and columnists proclaim that the cynicism and the amorphous evil forces that have blocked reform in the past will be defeated. The President avers the private health care industry vows to cut costs a few percentage points each year and save the average American family \$2,500 per year.

On closer examination, the euphoria quickly dissipates. Enhanced automation and financial access to health care likely will contribute to health status gains for some, but how the consensus solution will bring about the organizational and behavioral changes necessary to contain costs and enhance health status is vague and elusive. It addresses “what” we need to do, a conclusion about which there has been consensus for years. We must assure universal access to effective health care; entice individuals and communities to improve their life style practices and adopt proven preventive services and better prepare for the next “surprise”. To have the resources to accomplish these objectives we must improve the effectiveness and efficiency of health care delivery. The real issues involve “who” should do this, “where” and “how.” The State, unlike the nation, has started meaningfully to grapple with these issues.

At first glance, the national reform effort is perplexing. However, the strategic and tactical blueprint for this effort follows almost line by line that proposed in former Senator Tom Daschle’s book, Critical – What We Can Do About The Health-Care Crisis. Although Daschle withdrew as a candidate to lead the national reform effort, his reform plan is prominent. Daschle strongly admonishes reform architects to be purposely vague and eschew open substantive discussion in order to avoid the fate of the Clinton reform initiative. Citing past failures, he defends such an approach upon the premise that we must silence those enemies – who allegedly have passionately fought to prevent the Nation from achieving improved health care because of ignorance, inertia, base greed, and ignoble intent – through a rapidly moving, politically motivated, media driven, public relations blitz.

Substantively, he promises success based upon the assertion that central government - by tinkering with funding, cost-effectiveness research, and reimbursement policy - can assure the reform of complex local health care systems. During the past 50 years, most of these well-intentioned central government reform proposals, policies, and programs

have failed or resulted in increased costs and “unintended consequences” that often far exceeded any benefit.

As long as 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., individual patients, practitioners, and institutions will likely 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

Even if the nation realizes enhanced financial access and long overdue adoption/integration of automated health system information, it is doubtful the central initiatives will be any more effective in addressing many issues (e.g., improved life style practices, ideal organizational configuration, ineffective/futile care, lower costs) than they have been in the past. One can only hope that such a huge expansion of central spending and regulatory authority will not hamper or scuttle promising local health reform initiatives such as S-414.

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