Rethinking Health Care: An Opening Discussion

By Marvin W. Harrison, M.D.

As the expense of health care and the development of valuable interventions increase, we need to design a more efficient and effective health care system. If we proceed on our present course experts tell us that the debt for health care will balloon beyond our wildest nightmares and certainly beyond our collective ability to pay. In this scenario demographics are destiny, and a prolonged old age is a looming prospect for a larger proportion of our population than ever before.

One rough and cavalier approach is that referenced (with some seriousness) by such notables as medical practitioner Sherwin Nuland in his essay, "How to Grow Old" and economists Kotlikoff and Burns in their book *The Coming Generational Storm*. Briefly, it can be summed up as: "Live well and die quickly." "Live well" implies robust health for a goodly sum of years, which is fine. "Die quickly" relates to the fact that there is a huge expenditure on ineffective health care in the last year of life. The last year of life is not confined to old age, but includes any situation that results in the death of the patient: infant mortality, accident, disease, etc. requiring extensive medical resources such as emergency room care, extended hospital stays (particularly in intensive care units) as well as specialty consultations, surgeries and other extended, intensive therapy.

The reality is that medical care in the last year of life understandably is driven by a natural bias toward hope even in the face of futility. Families and patients wish for meaningful recovery, desirable quality of life and merciful comfort care, while demanding durable power of attorney over issues such as death with dignity and the reality of brain death.

Considering that we can not really anticipate all eventualities, an analytic approach toward health care in general may prove useful. To begin, we should define our goal. For the purpose of this discussion it is to provide health care for all of us who need it. With this as a starting point we may cautiously assume that some solutions to the "health care crisis" are attainable despite the very real complexity of the problem and the prevalent abundance of hand wringing, obfuscation and even duplicity. If we take a step back from our preconceptions and our learned jargon, assume we are all "stakeholders" and allow ourselves to look at the situation in different ways, we can achieve a health care system that is accessible to all and provides for each individual's health needs.

Thinking Anew

A friend tells an anecdote related by Stan Hallett, who was a member of the distinguished Urban Studies center at the Kellogg Graduate School of Management at Northwestern University. Hallett was interested in a phenomenon in Garfield Park, a large housing project for the poor in Chicago. In the face of very high unemployment, lots of public assistance money flowed to the area, most of it for health care, and yet the health indices of that population were well below an acceptable standard.

So the questions were, "What's the matter with the health of the people of Garfield Park?" and "What can be done about it?"

The medical profession had no explanation for the causes of the poor health, though it could provide precise information about its manifestations, like the number of broken tibias in a given year. An expensive set of medical remedies was proposed: more doctors, more nurses, more medical technology, and another hospital.

As this was not feasible, a study was initiated to ascertain the causes of poor health in the community. The findings were not unlike those of similar studies in other groups. The primary problem was a result of malnutrition. Another was recurrent trauma from car/pedestrian encounters in a congested urban population with very heavy traffic. Drug and alcohol abuse, personal assaults, including spousal abuse, and various gynecological problems were also common. It was clear that the planned medical response would do very little to prevent harm, though it might help patch up the injured. Despite scant resources, investigators set out to do what they could to address the causes in an effective way. They had a measure of success with malnutrition. Then they gained access to computerized traffic data, identified the locations of recurrent accidents, determined the causes, and encouraged engineering responses that addressed them. (such as correcting poor visibility and installing needed traffic lights).

THE BIG PICTURE

Percentage of health-care dollars spent on administrative overhead in the United States:

31

THE BIG PICTURE

Rank of the United States among other industrial nations in percentage uninsured:

1

Though it was not the most prominent health issue, the most innovative success was the creative response to the frequent occurrence of dog bites. There were lots of wild dogs, and lots of children, with predictable consequences. The first attempt to get better enforcement of laws pertaining to dogs failed because the control agency said it didn't have the money and, anyway, it was difficult to deal with wild dogs. They turned to the National Institutes of Health to get funding for enforcement, but were told that this was not an appropriate use of money assigned for "health" and were advised to apply for funding for additional nurses, trained to treat dog bites. Finally, they were able to utilize the public funding for a project to keep young men off the streets. They obtained money and put a bounty on wild dogs. With sufficient incentive, the young people were very creative in devising effective ways to capture the dogs, make some money, and virtually eliminate the problem of dog bites.

Accidents (unintentional injuries) rank 5th in the overall causes of death on both a state and national level. They rank 1st in the 25 to 44 age group measured nationally both by frequency of occurrence and loss of productive years. Unintentional injuries are most likely to be caused by poisoning (usually use of drugs in an illicit manner) in the 35 to 54 year-old age range. Falls were frequent in the elderly, while automobile accidents and guns were causes seen across all age groups. All of these accidents are entirely preventable. This is preventive care, and except for pre and perinatal care and

THE BIG PICTURE

Number of developed countries ranked as having better outcomes than the United States in infant mortality:

10

in low-birth-weight babies:

28

and in life expectancy:

5

immunizations, it requires no expensive intervention by the providers of health care.

By using all our powers of observation and our expertise in preventive medicine, we can free ourselves from old paradigms of inaction and effect savings not only of health care dollars but also of lives and productive years.

However, the story of the dog bites and their treatment suggests even more than the value of preventive care. The open minded exploration of problems can create new opportunities and efficient solutions if the goal is clear and the real causes of problems are identified and remedied.

Limiting Need

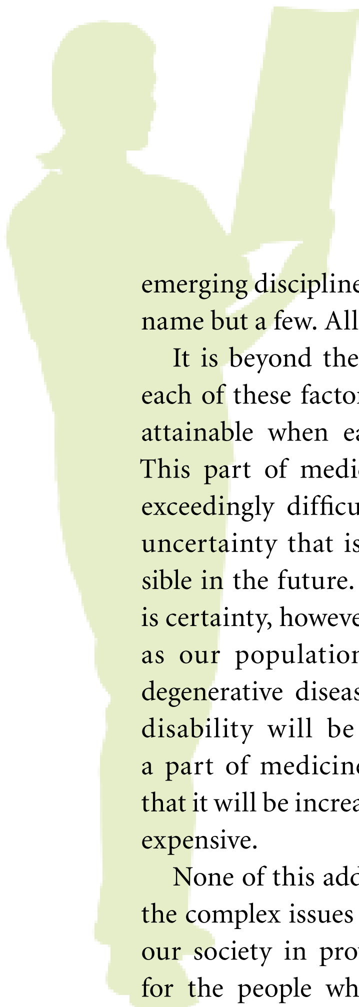
Treatments for various illnesses are not consistent throughout our country. We know this in large part due to the research of Dr. John E. Wennberg, director of the Center for the Evaluative Clinical Sciences at Dartmouth Medical School and publisher of *The Dartmouth Atlas of Health Care*, a large collection of medical data and analysis. In two papers published in 2004, Dr. Wennberg described the "Use of hospitals, physician visits, and hospice care during the last six months of life among cohorts loyal to highly respected hospitals in the United States" and the "Use of Medicare Claims Data to Monitor Provider-Specific Performance Among Patients with Severe Chronic Illness."

In both studies, he found considerable variation from region to region. For example, days in the hospital per decedent ranged from 9.6 (Hennepin Co. Medical Center, Minneapolis) to 27.1 (NYU Medical Center-University Hospital). Days in intensive care ranged from 2.3 (Fairview-University Medical Center, Minneapolis) to 9.5 (Thomas Jefferson University Hospital, Philadelphia). Number of physician visits varied from 18.1 (Hennepin) to 76.2 (NYU). Similarly, he also found that the cost of inpatient care during the last 6 months of life varied widely – from $17,797 in Manhattan to only $6,198 in Bend, Oregon, compared to a national average of $9,933.

There must be many reasons why care is so disparate from region to region, yet it is unlikely that the biology of individuals is significantly variable. The wide variability in Wennberg's data suggests that practices can be modified for efficiency so long as patients' goals are well understood. With this data and the skillful use of currently available modeling techniques we should be able to provide more efficient and cost-effective healthcare.

Determining Appropriate Treatment:

Beyond the differences in care described at the macro level by Wennberg, there is a very large and complex array of factors that bear on determining appropriate treatment. These include patient desires and expectations, ethics, foreseeable outcomes, alternatives, societal norms, the law, geographic and temporal constraints, and the



emerging discipline of evidence based medicine, to name but a few. All have a role.

It is beyond the scope of this essay to explore each of these factors. Nonetheless, efficiencies are attainable when each is considered individually. This part of medical care and its financing are exceedingly difficult to structure because of the uncertainty that is inherent in what will be possible in the future. There is certainty, however, that as our population ages degenerative disease and disability will be more a part of medicine, and that it will be increasingly expensive.

None of this addresses the complex issues facing our society in providing for the people who cannot care for themselves, either because of developmental disability, accident, disease or simply the aging process. This part of the social contract traditionally has come under the Medicare and Social Security rubric yet remains a critical element for further thought regarding its relationship to the overall costs of medicine.

THE BIG PICTURE

Rank among other nations in cost of health care per person:

1

Business Practices

Management and the market forces of our economy are used by business to create efficiency every day. This is not always seen as a happy activity. Yet Boeing moves from Seattle to Chicago, and the lumber mill is closed in Idana. Parts are made offshore; we buy shoes made in Indonesia and cars made in Japan, Germany, Sweden and even Detroit. We can not afford to insist that every hospital be equipped and staffed to do the full range of services especially as underutilization of the facility results in inefficiency that is compensated by high prices.

Also, a large dollar figure in healthcare spending is associated with insurance and medical administration. Compared with Medicare at about 5%, insurance companies spend about 31% of the premium dollar on administrative overhead, adding little if any value to the health of the subscribers.

Cost

There are many approaches to reduce the future actual costs of health care. The sections above suggest just a few of them. Our goal is to provide effective health care that people actually need and at a price we can afford. Analysis reveals that we are a long way from accomplishing this. Unless meaningful changes are made, the combination of a growing population in need of care and the increased possibility of necessary interventions will further aggravate the problem. How we will provide effective, affordable healthcare for ourselves, our parents, our children and for those of us who lack the necessary resources is a formidable but not impossible challenge.

The social contract is a real commitment to helping each other. It may be that we all have to do some work to realize the goal of affordable and effective healthcare. Creative thinking about definable problems will help greatly to identify the changes we will have to make. Who would have guessed there was summer work for teenage kids in a project that encouraged development of problem solving skills and saved younger children pain, suffering and fear?

In a related article, Michael J. Garland presents a poll of what one constituency, the people of the State of Oregon, said they wanted in a recent health care values study and one possible practical application of the results of that study. In upcoming fall and winter issues Open Spaces will continue the general discussion of creative approaches to providing effective and efficient health care. ▸