

## **INDEPTH BOOK ANALYSIS:**

### **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.

Thus, one gets the impression that if one were to raise a concern about the possible *unmentioned* "unintended consequences" (or costs) of certain proposed policies or actions, the authors likely would rule the information irrelevant, inadmissible, or out of order because it addresses a "goal" not "on the table" for discussion at a point in time. Trial lawyers - rather than individuals who have actually labored in the health care vineyards to improve the system and health status of the public – appear to have written the book.

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. He recognizes the value of "trust" but fails to realize it often relies upon appreciation of the concept of autonomy.

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. One, also, would like at least a mention and discussion of how patients in the US would react to the recent "non-mythical" case of a woman in England with breast cancer denied Avastin to extend her life or the multitude of

individuals denied, or on waiting lists, for dialysis, joint replacements, etc. in some 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”.

“We” need to address the vast majority of issues well articulated by Daschle. 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.

Most individuals, practitioners, and health institutions appreciate and support the central generation and dissemination of cost effectiveness, safety, efficacy, and other information provided by central government and private institutions, e.g., NIH, FDA, CDC, AHRQ,

A4Q, . They would not seek - or pretend to have - the expertise and capability to generate such information and guidance. However, much more than such cost-effectiveness and related information influences the best decision, i.e., course of action to pursue, for each individual and community. Moreover, it is naïve to believe local individuals and communities will ever fully trust a central entity to make such decisions. Daschle should at least entertain the possibility that shifting the locus of system reform responsibility to the local level – with corresponding mechanisms, authorities, and incentives - might be more successful than continuing the numerous failed centralized approaches of the last 50 years. In fact, one of the few health system reform cost-containment successes has been “tort reform” enacted at the local level – an area of reform ignored by Daschle. Daschle does not focus on the right “We”.

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”
- Perceived impotence, unwillingness, or lack of incentives for local communities (where real health systems, or the remnants of such, operate) to address known “behavioral” and “organizational”, i.e., waste, duplication, ineffectiveness, and inefficiency, problems (often supported by central government reimbursement/funding policies and other political motivations)
- 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, as well as the inability of centralized federal programs like the VA (with a premier system) to integrate it with various “outside” entities, because of political and other issues, in order to assure optimal case management.
- 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.

In his closing pages, Daschle presents moral imperatives, employing guilt and shame to entice Americans to embrace his cause. Again, he raises some legitimate concerns, but, again, is selective and vague as to the “We” that will interpret the moral compass.

Daschle repeatedly states or infers that cost-sharing or encouraging prudent “cost-comparison” consumption practices, is a bad idea since it will result in some individuals failing to get the care recommended and/or needed. As with the international “rankings” previously mentioned, the results are influenced by the study design, bias of the researcher and attitude of the individuals queried. However, many such surveys reveal that significant portions of the queried population claim they will not avail themselves of recommended care if it cost them anything. The corollary would likely be advanced by Daschle that all or most preventive and primary care should be “free” so folks will use it and avoid serious illness, death, disability, lost productivity, and more costly care down the road. Is this a morally responsible choice?

Is it not possible that many individuals simply prefer not to personally pay for health care as long as someone else, what I refer to as the “amorphous they”, will pay for it? Is accepting such a practice morally defensible simply because an individual “threatens” society that he or she will not get the recommended care for themselves or their children (but rather a boat or bottle of wine) unless the government, i.e., their neighbors, pays for it? Perhaps, Daschle’s proposed health board should start by defining what is the reasonable contribution each individual will be required to make based upon their family and economic situation. To a degree, Massachusetts does this by taxing individuals to defray premium costs. However, if folks still actually forego recommended care (not wanting to pay the reasonable cost-sharing theoretically defined by the national health board) and incur more expensive care or lost productivity down the road because of such neglect perhaps they should be “fined” accordingly. Building upon Daschle’s automobile

example, if one fails to replace his tires and is involved in an accident he would pay for such negligence. In fact, the central board could extend this principle to “tax” or otherwise penalize individuals who fail to adopt certain life style practices or avail themselves of recommended preventive services for cost or other reasons.

My moral contention is that individuals, especially able body citizens, have a personal obligation to keep themselves healthy, including obtaining and paying for health care according to their ability to pay, in order to contribute maximally to the economic and social well being of their community. I also believe – and trust most Americans would agree – that morally I have a collective obligation to assist the poor, sick, disenfranchised, and disabled within my community. Historically, most communities have always done so. However, I believe many Americans do not trust a central government “We” to define the proper balance between personal and collective moral responsibilities and would prefer that decision reside closer to home. Moreover, if resources are limited, I believe many American believe more prudent decisions regarding the effective and efficient use of these resources can, and - most importantly - will, be made closer to home. The record of accomplishment of centralized government, e.g., dialysis, over the last fifty years in this regard is not impressive. I doubt the national health board can, should or will improve this record.

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.

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