

What is missing from health system reform deliberations? September 2009

I have no problem with what President Obama stated in his health reform speech to Congress. My concern is with what was not stated.

Current system reform efforts involve three major issues: payment reform, insurance reform and system (delivery) reform. The first two – upon which the President focused - are likely to be addressed “centrally” and certainly will have some impact upon the system, i.e., delivery. However, they will not reform the delivery system.

The delivery system will either be reformed – or not – primarily at the local level. The proponents of reform proposals appreciate the above distinction and try to address it by proposing a myriad of “top down”, disjointed, theoretically worthy initiatives (many of which have been tried with marginal success over the last several decades), e.g., preventive programs including training, comparative-effectiveness research, automation, to fix the delivery system. They also overstate the impact insurance and payment reform will have on improving the delivery system. However, they present few numbers or details and little evidence, that the proposed massive expansion in government programs and expenditures will improve the delivery system. They refuse to entertain the idea that a better approach might be to provide funds or incentives to local communities to carry out this phase of reform.

Most citizens share health system reform substantive objectives to assure all Americans enjoy universal access to timely, high quality health care and embrace healthy life-styles and preventive care. Especially in this time of economic challenge, the key to success rests in the most prudent expenditure of resources to promote optimal system effectiveness and efficiency. In other words, the major challenge is how we pay for such reform and, if we cannot afford everything, how we prioritize.

My overriding concern involves the deliberation process, especially the paucity of “details” and “numbers”, including the research, assumptions, and analysis underlying current and projected measures. As troubling, is an apparent assumption that the problems and solutions are similar in most groups and communities. In fact, there is great “variation” among communities and certain demographic groups, such that “global” - rather than “targeted” - initiatives could result in increased ineffectiveness, inefficiency, and waste.

All Americans need health insurance protection from economic ruin in the event that they suffer a catastrophic medical event. However, in many communities, especially those with accessible federally funded community health centers (FQHCs), it is not evident expanded health insurance coverage will significantly change the number of individuals who receive timely, preventive and primary care - thereby averting costly emergency room care and more serious, advanced disease. Geography, physician/institutional supply/mix, education, culture, social factors, organizational integration, etc. might all have much more influence and represent “higher priority” areas to address.

Many proposals include a significant expansion of federal bureaucracy and funding for comparative-effectiveness research and expansion of evidence based medicine and preventive medicine programs. However, proponents present little hard evidence of projected savings, if any, or comparisons to the potential savings realized through serious tort reform by reducing unnecessary “defensive medicine” procedures. In addition, proponents offer little analysis

regarding how existing organizational and community factors might greatly influence the need for - and effectiveness of - such proposed measures in different communities, including such basic questions as how many local communities would afford certain health personnel, e.g., public health physicians, proposed to be trained.

In these times of financial crisis, proponents should provide such numbers – and the underlying evidence, assumptions and research – and/or they should delay certain global initiatives until times that are more economically prosperous. In addition, deliberators should consider providing incentive funds to each community or medical trade area, continuing such funding based upon the health delivery system cost-savings and other outcome gains realized.

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