

Health Care Reform from the Ground Up

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Since the early 1990s, America's welfare rolls have been slashed by half, teen pregnancy is down 20 percent, juvenile homicide arrests have dropped 50 percent, and poverty has declined each of the last seven years, with black and Hispanic poverty levels at all-time lows. However, one major social concern stubbornly refuses to surrender to new policy formulations: health care coverage for the poor. As a candidate for president in 1992, Bill Clinton declared it a crisis that thirty-seven million Americans were uninsured. By the end of his second term in office, the number of uninsured had risen to forty-four million, and it continues to increase at a rate of 100,000 people per month.

Sadly, lack of insurance among the poor is not the only major problem facing the U.S. health care system. Although the American system is universally (and correctly) acknowledged as the world's finest, quality of care is still a serious problem. In a seminal report issued by the Institute on Medicine, *To Err is Human* (1999), it was revealed that as many as 100,000 patient deaths each year are attributable to human error. This number, if accurate, makes the lack of patient safety one of the top ten causes of death in the United States, ahead of breast cancer.

Dramatic increases in health care spending complete the triumvirate of challenges that plague America's medical system. High costs affect others besides the health care consumer—just ask your local employer who is buckling under the weight of a 20 percent increase in his company's health care package after a double-digit increase the previous year.

The cost of health care delivery in the United States topped the trillion-dollar mark in 1996 and presently consumes 15 percent of the nation's Gross Domestic Product. According to research conducted by Nobel Prize-winning economist Milton Friedman, health-related spending in the United States multiplied twenty-three fold between 1919 and 1997, from \$155 per capita to \$3,625, in constant dollars. Friedman asserts that this increase has been driven almost exclusively by the rise of employer-provided medical coverage, which began for the mainstream population during World War II, and the introduction of Medicaid and Medicare for the poor and elderly, which began during President Lyndon Johnson's War on Poverty. (This finding becomes even more dramatic when one considers that the \$100 billion tax subsidy that employers receive for providing health care coverage for employees is not included in official health care spending calculations.)

These challenges have proven distinctly resistant to both public and private efforts to achieve solutions to America's health care problems. Every president from Nixon to Clinton tried and failed to slay the dragons of access, quality, and cost.

Prescription for Real Reform

For a solution that meets patients at their point of need, we must turn our attention away from the best and brightest analysts in Washington, D.C., and toward an Appalachian town in western North Carolina. In the heart of the Blue Ridge Mountains, a group of citizens banded together to form a multisector coalition that not only addresses, but also conquers, the access, cost, and quality concerns.

Some 15,000 of Buncombe County, North Carolina's 198,000 residents lack health insurance. These uninsured overwhelmingly represent the working poor who do not enjoy the benefit of employer-provided coverage yet earn too much income to qualify for Medicaid. This is the group that places the heaviest burden on local hospitals and community health clinics, because they often are unable to pay their bills after treatment. Because of these money problems, this population further complicates matters by not seeking proper care and failing to take prescribed medicine after visits to the physician.

Buncombe, like most communities, possessed a handful of doctors who would see these patients, but most in the medical community did not want to become known for offering such services, out of fear that endless lines would form outside their office doors. Doctors also worried that the charity patients they *did* see would not receive the necessary lab work and hospital treatment they ordered because of their inability to pay those fees for service.

Enter the Buncombe County Medical Society. With help from a \$100,000 planning grant from the Robert Wood Johnson Foundation, the medical society sought to create a rational and coordinated approach to providing appropriate access to care for the county's low-income population. Recognizing that this could only be accomplished by marrying early intervention and prevention to access to specialty care and hospital services, medical society officials established an initiative called Project Access to put the pieces together.

The first step was to recruit private physicians to offer free medical care to all who need it, the keystone of the initiative. To prevent overcrowding, Project Access capped primary care physicians to ten patients per year and limited specialists to twenty. A sophisticated data system was established to handle referrals and track office visits. In response, more than 80 percent of Buncombe County-area physicians agreed to participate. To address the doctors' concerns about patients seeking proper post-visit treatment, Project Access officials required participants to sign a personal responsibility covenant. On the supply side, project officials

secured a commitment from hospitals to provide services such as physical therapy as needed. The hospitals made this generous concession because, among other reasons, the uninsured population was draining their resources and clogging their emergency rooms—according to the American College of Emergency Room Physicians, this strain forced the closing of 1,128 emergency rooms between 1988 and 1998 and 500 hospitals between 1990 and 2000.

County officials agreed to pay for prescribed drugs, subjecting Project Access participants to a very affordable \$4 co-pay. Pharmacists, in turn, largely waived their dispensing fees and provided medication at an average of wholesale minus ten percent. Project Access patients carry a medication card like any other insurance card. The popularity of these medication cards reveals a key lesson relevant to all government programs: recipients want to be treated like everyone else. In fact, the stigma of dependency is high in the current era of welfare reform. In most states, roughly half of the families that have left welfare do not use Medicaid, even though the majority remain eligible and the benefit is a federal entitlement. Recent research indicates that although some families were not aware of their eligibility, many others forsook the coverage out of an unwillingness to put up with the attached bureaucracy or in a laudable attempt to remove themselves from the public dole completely.

Real Results

A scan of its results indicates that the Buncombe County plan is not simply a charity. The county government's annual investment is \$350,000 for medications and administrative costs, whereas \$600,000 formerly went to local hospitals for indigent care. This public investment, moreover, brings in significant private resources. Both hospitals and private physicians are seeing twice as many indigent patients as they did before, and the dollar value of their contributions has increased from \$1.8 million in 1997 to \$3 million in 1999. Patient care has improved as well. Of the 15,000 uninsured, 13,000 are participating in Project Access. Of these patients, 80 percent state that their health is better than when they started the program, and their use of hospital emergency rooms is 50 percent lower than among the county's general population. In all measures, Buncombe County's efforts have resulted in attainment of the federal government's *Healthy People 2010* goals a full decade ahead of schedule. "The best outcome for me is a note from a patient telling me that they are now able to return to work," said a Project Access architect, Dr. Suzanne Landis of the Mountain Area Family Practice. Her mailbox must be quite full: only 39 percent of participants are employed at the time of enrollment, but after six months in the program, the proportion working swells to 51 percent.

Buncombe County has achieved what many would have found inconceivable: engagement of eight out of every ten local physicians in volunteering care and nine in ten uninsured citizens receiving quality health care. This success has not gone unnoticed. The Harvard University

Innovations in Government Program selected Project Access for one of its Top Ten awards in 1998. With this prize came a grant to help other communities implement the model with essential adaptations to fit local conditions. Nine other communities have adopted the Project Access model, and three dozen others are in development.

Besides these direct followers, many other reformers across the United States are likewise concentrating on the “patient point of care” to design integrated systems of service delivery that improve health care and other services for the indigent or uninsured. Hillsborough County, Florida, for example, established “one-stop shopping” at twenty-four locations to provide indigent and working uninsured citizens a referral network of more than fifty services including not only health care but also other services such as food vouchers, energy assistance, job placement, and child care. The Jesse Tree of Galveston, Texas, created a universal application form to capture all the information that each public agency needs from clients to operate their programs. Muskegon, Michigan, expanded access to physicians by addressing the gap between privately funded and government-funded coverage. A 1999 survey of county businesses with less than twenty employees found that 64 percent could not offer health coverage, with 69 percent citing cost as the primary reason. Hence, Muskegon officials created Access Health and made it available to individuals through employers. The employer and employee each pay 30 percent of the cost, and the remaining 40 percent is covered by the community. The community contribution combines federal, state, and local funds, so that every \$1 of public money brings in \$2 of private funding. After eighteen months, Access Health was serving one thousand individuals and three hundred businesses, and it continues to grow. Both of the city’s hospitals and two hundred of its physicians—97 percent of all local providers—participate in the plan.

Other innovative communities are applying sophisticated knowledge of risk factors to identify those who can benefit most from intervention. According to the federal Health Care Financing Administration, between 3 and 5 percent of U.S. health care patients account for more than half of the medical costs paid for by their insurers. Hence, many communities are taking approaches similar to those of population risk management firms. One such firm is FutureHealth, which manages 400,000 people in insurance pools nationwide. According to the *Washington Post*, FutureHealth “operates under the revolutionary principle that identifying the small percentage of patients in an insurance pool who are most likely to land in the hospital and then devoting resources to keeping them healthy can significantly reduce the cost for the entire group.”

According to a tracking process established by the U.S. Bureau of Primary Health Care, more than five hundred community leadership teams from across the nation have begun to create integrated, primary-care-based, community health systems that realize seemingly contradictory principles: better health for more people at lower cost.

Federal Turnabout

With all this success swirling about, these local innovations are already influencing the national policy debate. The community-based solutions described here were achieved without federal permission, funding, or oversight, and these and other communities could reach even greater success if the federal government were to implement similar reform strategies. Although it cannot heal the nation's health care system itself, the federal government does have a meaningful role to play in any reform effort. The community solutions described here represent the most promising new approach to health care reform in quite some time, and the federal government can apply the same principles to its own efforts, particularly by supporting such local initiatives.

Accordingly, the Bush administration has committed itself to such an approach through a "compassionate conservative" formula of expanding infrastructure and implementing a new federalism in this area. The Presidential Initiative on Community Health Centers is the administration's signature initiative in this realm and will serve as the chief vehicle for expanding America's public health infrastructure. The president's FY 2002 budget increased federal funding of health centers by \$124 million, bringing the total to \$1.3 billion, as part of a multiyear initiative to support twelve hundred new or expanded health center sites. Approximately 11 million people are currently being served at more than three thousand health centers, and Bush wants to increase the number of people served by 6.1 million and raise the number of clinics by 40 percent over the next five years.

In addition, Bush and Secretary of Health and Human Services Tommy Thompson are giving states greater discretion in implementing federal programs in this area. One of Secretary Thompson's first initiatives was a model waiver program that gives states increased flexibility in running Medicaid and State Children's Health Insurance Programs (SCHIP), reversing burdensome rules put in place by President Clinton in his final days in office. Thompson said, "Our goal is to give governors the flexibility they need to expand insurance options available in the private sector."

Changing Incentives

There remains room for continued debate on the national stage. People on all sides agree that ample resources exist to repair the broken parts of the nation's health care system, which accounts for approximately 20 percent of the economy. The question hinges on how to achieve a better return on that investment. That means getting the incentives right. Sheila Burke, former chief of staff to Bob Dole and author of much of the Medicare law reform of two decades ago, is among the many who lament the myriad unintended consequences caused by the misplaced incentives that federal program creates.

Milton Friedman emphasized this point in a Winter 2001 *Public Interest* essay on "How to Cure Health Care." Friedman argues that the best way to get the incentives right is to jettison the entire third-party payer system, advocating such dramatic measures as a repeal of the tax exemption for health insurance provided by employers and the termination of Medicaid and Medicare. Friedman envisions employers switching costs from health care coverage to higher wages, enabling employees to purchase their own plans, presumably on more competitive terms than impersonal, bulk plans can achieve. To handle the hard cases, he would shift spending on federal health plans to state and local governments. Friedman acknowledges the political futility of such a scenario, but he issued his proposal to spur policymakers to identify the ultimate destination as a standard by which to judge the relative merits of each incremental reform. And although Friedman's plan in toto is a non-starter, many of today's incremental reforms fit the pattern very well. Consensus, in fact, is emerging around two measures that may be just what the doctor ordered.

One is a wide, bipartisan push for refundable tax subsidies for people who buy health insurance from private, competing plans. Such tax credits were a key plank in President Bush's campaign and in the legislative agendas of many leading Democrats. In an October 2000 essay in the *Atlantic Monthly*, journalist Matthew Miller recounted an interview with two U.S. Congressmen, single-payer advocate Jim McDermott and free marketeer Jim McCrery, during which the two influential health care experts on the House Ways and Means Committee hammered out a consensus plan for tax credits. To achieve such agreement in Congress, Miller noted,

The story of the coming 'grand bargain' on health care is one of Democrats accepting the existence of a private insurance industry and Republicans accepting the need to help make sure that everyone can buy a decent policy. It is a story of liberals agreeing that innovation shouldn't be regulated out of U.S. health care and conservatives agreeing that justice has to be regulated into it.

One such proposal, offered by the liberal Progressive Policy Institute (PPI), recommends tax credits of up to \$2,500 for those who purchase private insurance and up to \$1,000 for those who use employer-provided plans. Gaining steam on the market side is a movement to create medical savings accounts (MSAs) as a first and forceful shot across the bow of the third-party payer system. Medical savings accounts combine a high-deductible health insurance policy with tax-free contributions to the MSA. MSAs make individuals financially responsible for their own health care decisions, and provide a financial incentive for frugality—any unspent MSA funds at end of year can be rolled into the next year's expenses or withdrawn for other purposes. The Kassebaum-Kennedy health care reform of 1996 included a limited pilot program authorizing MSAs, and a growing number of legislators has expressed interest in expanding the program.

In addition to this federal legislation, a number of major corporations now offer employees the option of taking MSAs instead of regular, low-deductible insurance policies. Beyond America's shores, South Africa has become the political leader of the MSA movement. According to Shaun Matisonn of the National Center for Policy Analysis, Nelson Mandela created a very favorable environment for free-market health care coverage through deregulation in 1994. Since then, MSAs have captured half of the South African private health-insurance market, with impressive results—MSA families reduced their per capita health care spending to half of what is spent by those in non-MSA plans.

Tax incentives, medical savings accounts, and the innovative solutions advanced by multisector actors in communities across the United States all score well on Friedman's test of incremental reforms moving toward a market-based health care system. Nearly one in five dollars spent in the U.S. economy goes to health care, so there are clearly enough resources to achieve even the most ambitious goals. The lesson of Buncombe County, North Carolina, is that community ties, not federal strings, best enable the nation to invest those resources in a healthier future. <http://www.sipr.org/>