

## CHAPTER 3

# THE BIG LIE: HEALTH CARE IS UNDERGOING RAPID CHANGE

Health care is said to be in a frenzy of change, what with rising costs, the demise of managed care and the questionable financial viability of Medicare and other programs. These are only symptoms of a larger problem. Not much has changed in seventy years, except rates and payment structures, which are simply new window dressings on the same old mannequin.

Prior to the Depression of the 1930's, most people did not have health insurance. They paid cash to doctors and hospitals, who in turn provided charity care, and/or exchanged services for those who could not afford it.

Health insurance as it is currently structured is based on the model developed by the German Chancellor Bismarck in the late 1800s. By having health insurance, he reasoned, Germany would have a healthy—and therefore more productive—working population. He used employers as well as government to offer health insurance. This social insurance model is used by most of our

European cousins. We were about to adapt that model when World War I erupted—and we could not adopt a program that was initiated by our adversary.

Blue Cross and Blue Shield insurance emerged during the Depression as a way to keep hospitals and doctors solvent when most of the population could not afford to pay their food bills or mortgages, much less their doctors. It was also a way to keep physicians and hospitals independent rather than controlled by the government.

Health care costs, however, were a major concern after World War I and prior to the Depression. In fact, in 1929, a private commission called **The Committee for the Cost of Medical Care** was created to make recommendations about how to contain the costs of American health care. The problems identified by that Commission remain problems facing the health care system today.

The Committee issued its report in 1932, saying our health care costs were so high because:

- 1) we have a disease-based system of care rather than a prevention-based system of care (still true);
- 2) too many physicians were specialists (then 45 percent now 80 percent);
- 3) there were too many infectious diseases (this was before antibiotics and the other miracle drugs);

4) we don't have a community-based focus of care (still true)

Not much has changed. This is the new millennium. We still have too many infectious diseases, but of different kinds. Some conquered killer diseases, such as TB, are coming back more virulently. People are now living longer, but with more chronic-care than acute care need, and we may be developing resistance to our antibiotic wonder drugs.

More physicians are specialists rather than family or primary care practitioners. The problem with too many specialists is that they make their money by seeing patients and ordering procedures—heart surgery, knee replacements, you name it. Their incentive is not prevention. If diseases were prevented or significantly changed, they could go out of business or, at the very least, would have less work. Those of us with insurance use that insurance to replace hips, knees, and so forth—and then complain about rising health care costs.

We still have a disease-based system of care that currently is wearing a managed care mask. And, we still do not have a community-based system of care.

To repeat, we have a business-to-business model of health care. Because we have a business-to-business model, the health of the community is ignored. The need to generate patient revenues

creates duplicated services in communities so hospitals and doctors can have greater market share. However, in small, rural communities some of these same services don't exist at all.

Prevention on any scale is being done only by the public health system and the community and migrant health centers. Health plans don't want to do it because they get no financial benefit.

Even managed care that was supposed to offer prevention and wellness programs for the first time really didn't deal with prevention. The plans didn't want to. I have been told by medical directors and health plans administrators it is "not worth our time and effort and expense to develop prevention programs, because patients don't stay in our plan long enough for us to re-coup the costs of our investment and other plans will benefit from our work."

They think offering aggressive smoking cessation programs or weight management programs, or even covering the costs of medications to quit smoking are not worth developing or offering, because the average patient is in any given health plan for three years or less. The same is true for disease management plans for patients with diabetes or asthma. As managed care erodes, many clinics cannot afford to use the disease management programs they have developed for managed care, because they have no means to bill for those services. Under managed care they got a flat fee, which would cover a variety of services.

Under the fee-for-service model, services are billed by physician office visits, not visits with other health professionals who typically staff those programs.

The business-to-business approach means the insurer serves the employer who likewise may or may not care about wellness programs depending on employee turnover in their company. Employers focus on the bottom line, not the health and well-being of the community. Their focus is on their employees. When they can no longer employ them, they lay them off without any attention to the community infrastructure and capacity to provide necessary health care services for these now largely uninsured former employees.

## **RATES, REGULATIONS AND BODY PARTS**

Because we have been a disease-based system of care, we have had to demand legislation to add programs that are considered preventive. Mammogram coverage for Medicare, for example, required an act of Congress. Access to contraceptives has taken two Supreme Court decisions.

Traditional fee-for-service insurance did not cover preventive care, such as routine physicals. The notion of covering services or products that could prevent diseases or catch them early on has not been in most health insurance packages, because an insurance model is not a maintenance model, it is a catastrophic model.

American health benefits are basically medical. Period. The end. This means they do not cover

things like glasses, hearing aids, prescription medications, contraceptives, much less dental health. If something is wrong with the body, we are great at fixing it. By doing so, we have managed to compartmentalize health and created health benefits that focus on fixing body parts rather than promoting health. And we still consider oral and mental health as being separate and distinct from our physical health and well-being as well as our health care benefits.

We have done this from the get-go.

All we have done with these changes is try to figure how to *pay* for health care. We tried paying what hospitals and doctors charged, then we tried a prepaid, flat fee managed care payment structure. Managed care was supposed to provide the incentive for prevention that had been missing in our system, but it didn't work. On the plus side, it did cover the cost of annual physical examinations, but has done nothing long-term to solve the cost problem or increase the availability of insurance for more Americans.

Instead, it has succeeded in adding cost by adding administrative complexity.

And, be prepared for higher costs—there is no way costs can go down as the boomers glide into geezers.