

Local Access to Universal Health Care in Lewis & Clark County Addenda to a Report from the City-County Board of Health Task Force April 2011

During our deliberations and research a number of issues arose and/or were discussed that were indirectly tied to our charge or to our capacity to undertake careful inquiry.

A sample of these items may serve to meet the Health Board's need to move ahead on health related issues including issues relating to costs, access and the organization of health care process and practices.

The examples, which follow, will illustrate the nature of some of the lessons learned and/or discussed during the process of our meetings. Time limitations as well as the nature of the charge given to the task force; limit our ability to endorse any one of them.

A note of caution from the Task Force Chair, Beth Sirr, ARNP: Re "health care" as a "human right," I think any proposal using these terms will need to define them both. At the beginning, our group did attempt to define what we each meant by "health care", but we never arrived at a consensus. I don't remember even discussing what we meant by "human right". A man on the street might point out that "society" also has rights, for example, having to pay for the consequences of unhealthy personal choices or choosing not to do so (Sirr). Major state programs (e.g., Massachusetts) have been started without a health plan (leaving a definition of 'health care' to the whims of insurance companies and the 'market place') or a budget, while others (Oregon) have struggled after clearly defining a state health care plan. (Putsch)

Addressing primary care shortages - The CHC in Libby created an "umbrella" for private doctors providing OB services which provided them with malpractice coverage under the Federal Tort Claims Act (FTCA). This allowed the private doctors to continue to provide OB services in Libby. FTCA coverage might allow doctors in Helena who are otherwise retired completely to work part time without the burden of paying malpractice. Doctors or perhaps even nurse practitioners willing to work part time could make a big difference for those lacking primary care providers. Similar efforts have been undertaken in the State of Washington where retirees can serve in not for profit community clinic settings. (Sirr) Abundant evidence demonstrates that adequate primary care resources are key to better outcomes and lower costs.¹ (Putsch)

Providing greater access to care – San Francisco has initiated a program, Healthy SF, that in 2011 included 55,000 residents, the city's program offers prevention and primary care coverage.² The county spent \$126 million on the Healthy SF program during fiscal year 2008 to 2009.³ According to a 3/17/09 Kaiser Report coverage through Healthy San Francisco cost about \$280 per month per person in 2009, compared with an average monthly cost of \$388 for a Kaiser Permanente health plan and \$618 for Anthem Blue Cross coverage.⁴ (Putsch)

¹ Phillips RL and Starfield B: Why Does a U. S. Primary Care Physician Workforce Crisis Matter? **Am Fam Physician** 2004;70:440-46.

² Wildermuth J: Healthy San Francisco clears last legal hurdle: U.S. Supreme Court Justices refuse to hear challenge by restaurateurs to S.F. program providing coverage to residents. **SF Chronicle**, June 29, 2010.

³ <http://www.kff.org/uninsured/upload/7760-02.pdf>

⁴ <http://www.kaiserhealthnews.org/daily-reports/2009/march/17/dr00057520.aspx?referrer=search>

Electronic Medical Records - The VA's EMR system, Vista, could be considered. It was developed with federal funds and can be purchased for under \$100. It is the most widely used EMR system in the U.S., but is also used by 17 other countries including Germany. (Sirr) Commercial vendors of EMR's are numerous – but the Health Board would be wise to look at systems that are patient oriented, systems such as the VA's Vista, or the system currently in use at the Mayo or Denver Health – a major city hospital and its clinics. (Putsch)

Community engagement in health care planning and operations – A number of health care systems (large and small) have highly developed systems to integrate community needs and voice into the process of planning and carrying out health care programs. These include CHC's such as the Lowell Community Health Center, Lowell, MA, and Project Vida in El Paso, Texas, as well as larger systems such as Harborview Medical Center, Seattle, WA, and the Alaska Native Medical Center, Anchorage, AK.⁵ Institutions, such as the then Sutter Merced General Hospital, and the University of Washington Medical Center, have experienced extensive public exposure as well as trouble cases and developed programs to meet focused community needs as well as incorporate special community issues into ongoing program and planning.^{6,7} These efforts conform with at least one of the standards developed by the US Office of Minority Health which reads: "Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing health care related activities."⁸ (Putsch)

Comparative Cost Assessment (Local and Regional) – The Dartmouth Health Atlas is a useful tool. It uses an interesting methodology to provide comparative costs between hospitals and regions. In general health care expenditures in Montana during the last two years of life are remarkably lower than in many other states. Furthermore, within the state, selected institutions or regions spend more on care in the last two years of life than others. Helena, for example, is in the "Billings Region," as defined by the atlas, a region that has higher end of life care costs than the "Missoula Region." The Dartmouth Atlas was highlighted by Atul Gawande, MD, a Harvard based surgeon and author in his excellent June 1, 2009 article entitled: The Cost Conundrum: What a Texas Town Can Teach Us about Health Care.⁹ (Putsch)

Current literature about health care financing – Two studies undertaken with different methodologies estimate that 31%¹⁰ and 34%¹¹ of every health care dollar is consumed by overhead. In 2003 Don McCanne, MD, writing about the failure of incremental reforms (see

⁵ Putsch, R, SenGupta I, Sampson A and Tervalon M: Reflections on the CLAS Standards: Best Practices, Innovations and Horizons. October 2003 <http://www.xculture.org/research/downloads/CLAS.pdf>, October, 2003 or minorityhealth.hhs.gov/assets/pdf/checked/reflections.pdf

⁶ Fadiman A: **The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors and the Collision of Two Cultures.** New York, Farrar, Straus and Giroux, 1997.

⁷ Allen-Barnes A, Canfield J, Larson E, Putsch R, Thomas E: **Brokering Community/Institutional Relationships: The roles of training, mediation and negotiation in conflict resolution and change.** Society for Applied Anthropology, 3/7/97

⁸ U.S. Department of Health and Human Services, Office of Minority Health, National Standards for Culturally and Linguistically appropriate Services in health Care, Final Report, Washington DC, March 2001.

⁹ **New Yorker**, June 1, 2009, this highly readable article can be downloaded free from the internet.

¹⁰ Woolhandler S, Campbell T, Himmelstein DU: Costs of Health Care Administration in the United States and Canada. **N Eng J Med** 2003;349:2461-64.

¹¹ Kahn JG, Kronick R, Kreger M and Gans DH: The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians and Hospitals. **Health Affairs** 2005;24:1629-39.

below) pointed out that “we are spending more on health care administration alone than is allocated for our entire national military defense budget.”¹² The current insistence on free market, choice and competition has led insurance companies to offer and write unique policies. As the number of plans has proliferated, billing systems are forced to gear up to deal with the unique exclusionary clauses, co-payments, and coverage rule sets. One pharmacy in Helena estimates that it deals with 600-700 different health plans per year and carries an overhead of ‘over 40%,’ and a second pharmacy director agrees with the overhead figure.¹³ As if to illustrate the problem, In 2004 the National director of Blue Cross/Blue Shield stated that there were over 17,000 health plans in the city of Chicago.¹⁴ Additionally, over 61% of every dollar spent on health care in this country is tax-based.¹⁵ Older estimates were lower because they failed to account for ‘private’ insurance purchased by tax dollars on behalf of employees of federal, state and local governments. Earlier estimates also failed to account for the cost of tax incentives offered to encourage employers to purchase ‘private’ health insurance (plans such as Insure Montana). Montana’s 2008 health care spending was estimated at 6.8 Billion, or \$6572 per capita.¹⁶ At 31% overhead,^(see Woolhandler, 2003) Montanans spent \$1980 per capita on health care administration during that year. (Putsch)¹⁷

Incremental efforts to achieve universal health care¹⁸ – Incremental state health reforms have attempted to “plug the gaps” in health insurance coverage through new or expanded programs. These reforms rely on new taxes, are subject to appropriations and have often attempted cost-containment measures. The most recent example prior to passage of federal legislation is the Massachusetts bill passed 4/12/06. The Massachusetts plan was similar to earlier bills in scope and structure. Its individual mandate to purchase insurance (for families over 300% of federal poverty) was a significant, new addition to attempts at incremental reform. Earlier attempts include:

Hawaii Prepaid Health Care Act (1974),	Florida Health and Insurance Reform Act (1993),
Washington Basic Health Plan (1987),	Washington Health services Act (1993),
Massachusetts Health Security Act (1988),	Utah Primary Care Network (2002),
Tennessee, TennCare, (1992),	California Health Insurance Act (2003),
California Affordable Basic Health Care Act ('92),	Maine, Dirigo Health (2003),
MinnesotaCare (1992),	Vermont, Catamount Health Plan (2006).
Oregon Health Plan (1992),	

None of these programs have succeeded in achieving universal coverage. TennCare was one of the most expansive and expensive programs. By 2005 TennCare covered 1 out of every 4 Tennessee residents. TennCare’s 2004-5 Annual Report described the dilemma: “Despite the successes of extending health insurance to hundreds of thousands of non-Medicaid eligible Tennesseans through TennCare over the past 11 years, 2004 represented the year the state could no longer ignore the impending fiscal crisis that TennCare threatened ... if left unchecked, TennCare would

¹² McCanne D: Why Incremental Reforms Will Not Solve the Health Care Crisis. *J Amer Board Family Practice* 2003;16:257-61.

¹³ Helena pharmacy directors, discussion with R. Putsch in 2009.

¹⁴ Kazel R: Blue Crossroads: Insurance in the 21st century. *AMA News*, 9/20/04.

¹⁵ Woolhandler S and Himmelstein DU: Paying for national Health Insurance – And Not Getting It: Taxes pay for a larger share of US health care than most Americans think they do. *Health Affairs* 2002;21:88-98.

¹⁶ Steve Senninger, PhD - personal contact and review of power point material on MT. health care costs, 2008.

¹⁷ Disclosure, Bob Putsch is an active, volunteer member of Physicians for a National Health Program, a national organization advocating for passage of an improved “Medicare for All.”

¹⁸ Day B (MassCare): Why Incremental Health Plans Fail: Lessons from Six States. PNHP web-site, posted 2008.

consume 91 percent of all new revenue growth by 2008, essentially eliminating the state's ability to fund other state departments and priorities.¹⁹ (see Day, 2998) Massachusetts, now with less than 2% of its population covered, is struggling to control costs. At present, Governor Deval Parick has proposed new programs to attempt cost containment.¹⁹ (Putsch)

Current Attempts to achieve statewide universal health care via single payer – The Vermont legislature is in the process of passing a universal coverage, single payer health care bill. The current legislation passed the Vermont house 92-49 on 3/25/11.^{20,21} Vermont's governor, Peter Shumlin, ran on the promise to sign such a bill if it were to be passed (Vermont's first SP bill passed through the legislature in 2003 and was vetoed). The California Legislature passed SP bills in two different years, both were vetoed by Governor Schwarznager. On April 26, 2009 the California Democratic Party endorsed SP legislation and declared HC to be a right rather than a privilege.²² A representative of Physicians for a National Health Program estimates that 15 states currently have SP legislation under way. (Putsch)

Denver Health: Bailing out a major, heavily indebted hospital and system –The old Denver General Hospital has been reorganized as Denver Health under the leadership of Patricia Gabow, MD. She has taken on and expanded a system that was over \$38 Million in the hole when she started (1992), has over 400 beds, and supports an extensive community clinic system. Denver Health did \$380 Million in uncompensated care in 2010 alone, and while they have expanded the system and rely on poorly funded coverage (63% Medicaid or Medicare, while only 9% have commercial insurance), they have remained in the black ever since Gabow took over!²³ While pot shots have been taken at the system,²⁴ Denver Health has been lauded in a Kaiser commentary about its work as a city-wide health care system as well as by a recent award from the Association of American Medical Colleges for its role as a teaching institution.^{25,26} (Putsch)

¹⁹ Goldstein A: Massachusetts, pioneer of universal health care, now may try new approach to costs. **Washington Post**, 4/15/11.

²⁰ From the Associated Press, cited in **Kaiser Health News**, 3/25/11

²¹ <http://pnhpcalifornia.org/2011/03/vermont-universal-health-care-bill-passes-89-47/>

²² <http://www.pnhp.org/action/california-democratic-party-endorses-single-payer>

²³ Potter, M: One of these Docs is Doing Her Own Thing. **5280 Magazine**, April 2011.

²⁴ Steers S: A Healthy Paycheck: Denver Health may cut services, but its execs won't feel the pain. **Denver Westword News Thursday, Jun 27 2002** <http://www.westword.com/2002-06-27/news/a-healthy-paycheck/>

²⁵ Villegas, A: Checking In With Denver Health CEO Patricia Gabow On A "Model" Health Care System. **Kaiser Health News**, 8/14/09. <http://www.kaiserhealthnews.org/Checking-In-With/Checking-In-With-Patricia-Gabow.aspx>

²⁶ AAMC: 2010 David E. Rogers Award Patricia A. Gabow, M.D., Denver Health. Posted on the net at https://www.aamc.org/initiatives/awards/2010/155680/2010_rogers_award_recipient_gabow.html