

**A PRIMARY CARE POLICY FOR HEALTHCARE
REFORM IN IOWA**

**A Presentation from
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to the Health and Human Services Appropriations Subcommittee
January 18, 2007**

A PRIMARY CARE POLICY FOR HEALTHCARE REFORM IN IOWA WITH A FOCUS ON PUBLIC SECTOR SUPPORT

I. Introduction

Most attempts at healthcare reform focus on financing mechanisms: how to make care coverage available to the more than 46 million uninsured in the U.S. But there is much evidence to suggest that any reform attempt that focuses mostly on financing will fail (primarily due to cost issues) unless it addresses underlying issues in the basic structure of healthcare in this country. Many good studies have identified three of these structural inadequacies as critical: 1. The lack of an organized properly supported primary health care system; 2. Lack of coordination throughout the entire healthcare system; and, 3. Muddled ethical thinking that cannot clearly set priorities for the country or our people.

A brief word about each of these.

1. Lack of an organized primary care system. The U.S ranks number one in the world in only one indicator of healthcare adequacy – dollars spent per citizen. Despite these expenditures, we are far down the list in all measures of outcome or quality (such as life expectancy, immunization rates, or infant mortality). Why do we get so little for our dollar? One reason is the lack of coordination within our total care system resulting in wasted dollars (see number 2, below). Another is unhealthy lifestyles leading to an increased and costly care burden. A third is the 46 million uninsured who often lack access to care and thus pull the averages down. All of these failings can be addressed with an organized and fully supported primary care delivery system. In fact, coordination of care, lifestyle intervention, and providing basic care for all, are key components of any primary care system. Studies of care in modern countries that outperform the U.S. directly link increasingly positive quality outcomes to the adequacy of the primary care infrastructure. These positive outcomes are not the result of highly specialized, technology laden, clinical interventions.

2. Lack of coordination. There are some who believe there is already enough public money in the U.S. healthcare system (or, commonly called “non-system”) to cover all of our current uninsured, at least for basic health services. This is actually related to the primary care issue, above, in that our current system has been driven by ever increasingly highly specialized care for many decades. The result is now a plethora of programs designed specifically for single-issue interventions. For example, a low income, pregnant woman with children may rely for her care on not only the Medicaid system, but also Maternal and Child Health funding, WIC funding, CDC funding for immunizations, TB or STD testing (all separate CDC programs), Family Planning dollars, a Community Health Center to coordinate her care, Ryan White for HIV testing or care if needed, and the list goes on. Each of these programs have arisen because specialized interests saw a need and then determined that only they can provide these services in a proper fashion. Each of these programs carries an administrative burden at the federal, state and organizational level, because each requires separate accountability for quality of clinical, fiscal and administrative services. In a fine note of irony, this complexity has produced an entirely new health professional in the last two decades, the case manager or care coordinator. Their role is simply to help the patient and the healthcare provider navigate the ever increasingly complex healthcare system. At the same time the basic programs sited in

the example above are clearly within the capabilities of the primary care sector. Dollars that are spent to support the current redundant and bureaucratic programs could be spent on direct services.

On another level, the focus on specialized programs has also produced a lack of coordination of care among health professionals themselves, and difficulty documenting that care in the patient record. Each specialized service or provider sees no responsibility for the total care of the individual, and only Public Health sees any responsibility for a community of people. Unfortunately, Public health is often marginalized at the periphery of the care delivery system, with minimal ability to intercede on the part of the public's health except in cases of emergency. (This is a private sector issue as well as one of tax-supported care). An example of adverse outcomes from lack of coordination at the health professional level is the expense of repeated unnecessary testing procedures. Related patient safety issues occur when no one is documenting the specific needs of an individual and mammograms are not done, immunizations missed, or similar drugs issued from two different providers of care.

3. Ethical considerations. Is it ethically sound for some of our citizens to have access to any care they desire and others to go without basic care? Is it consistent that no health care provider feels responsible for a patient or community's overall care and at the same time patients and communities do not have access to the data and information they need to make informed decisions? Do we want our residents going without immunizations or care for infectious disease or mental health problems that may put the larger community at risk? Do we want to defer basic care for some knowing that the later cost to society will be greater because of denial of that care? Are the extraordinary expenditures that occur in the last days of our lives always warranted or even desired by our people? These are ethical questions that have not been properly debated.

II. Proposals

This paper provides some policy suggestions to incorporate in any reform legislation aimed at broadening access to care for uninsured Iowans. They should be an integral part of any fiscal proposals. They are aimed particularly at public dollars and the "safety-net" providers of our state, including Public Health, though also have relevance to private sector care. They do suggest a new focus on primary care and away from inpatient care, though coordination with inpatient services is crucial to overall success. We acknowledge the work of Sara Rosenbaum, J.D. of Georgetown University and her paper "Laying the Foundation", June, 2006, for some of these concepts.

1. Make a "primary health care home" for all Iowa residents within the next decade an explicit goal of reform.

Primary care is relatively inexpensive. At the same time, achieving a primary care system that functions well takes as much planning and policy development as retooling any other aspect of health care. Simply reducing expenditures for inpatient care will not yield advances in primary care. Therefore, it is important that the goal of assuring a primary health care home for all state residents be made explicit and that it receive the same careful attention as reforms in financing, specialized and inpatient care.

2. Develop strategies to maximize patient self-management of their own health, and empower them to be knowledgeable consumers of health care.

US healthcare has been traditionally one in which the patient is generally a rather passive participant in the process. Health professionals generally advise patients of what is best for them. In particular, glaring gaps in this approach appear when advice is aimed at behavioral issues such as diet, exercise, and the use of chemicals substances. The new health information technology allows a patient to have access to issues of specific importance to her/him, a record of clinical findings, and provide guided advice for moving forward. New health literacy and education formats encourage patients to take more control of their own health. But again, these are not simple issues and deserve the same attention that will be devoted to the next high technology development.

3. Support health information technology and its link to performance improvement in the primary care setting.

Much attention has been given to the adoption of technology in hospital settings. Yet in no health care setting will adoption of safe, secure, and interoperable health information technology be more important than in primary care, where the bulk of health care is delivered, where a consolidated health history must be maintained, and where the support and safety enhancements offered through HIT will experience their most constant use. In primary care, not only can we track the needs of individuals, but also needs of entire communities. For example, using an electronic disease registry, Iowa's community health centers can document that they have dropped the average Hemoglobin A1C among over 5,500 diabetics from over 8.2 down to 7.5, with considerable cost savings to the taxpayer for the future care of these patients.

4. Ethical issues need to be addressed.

There should be vigorous and thoughtful debate on all of the ethical issues raised in the introduction. Participants should come from all parts of our society. New ideas should be sought out and piloted. For example, can systematically encouraging 'living will' discussions in the primary care setting curtail some end-of-life interventions and related expenditures? Could focus on health literacy and self-management at the primary care level begin to reverse the slide into increasingly destructive lifestyle habits?

5. Two financial concerns should be addressed.

a. Ensure adequate financial support to recognize costs incurred by the primary health care safety net.

The large proportion of our under- and uninsured population makes ongoing support grants absolutely critical to the survival of the primary health care safety net. For example, the federal funds that flow to health centers represent an operational subsidy lifeline that help anchor health centers in communities that otherwise could not afford to maintain a health care infrastructure. Yet even for health centers, these funds cover only a fraction of the health care they must furnish to their uninsured patients and provide seriously inadequate support for referral and specialty care. The same need for operational subsidies through a strong

uncompensated care pool exists among the state's major hospital-based providers of health care for uninsured and under-insured low-income populations such as the University of Iowa and Broadlawns Medical Center. They furnish a disproportionate share of specialty and inpatient care received by low-income patients referred from the primary care sector.

b. Act to stem the erosion in primary care capacity, especially for populations at risk and the health care “safety net”, through payment reforms that reward results and incentivize investment in quality of care improvements.

It is very hard to move forward with improvements as the system continues to erode. As with other services, the accessibility and quality of primary health care is sensitive to payment incentives. A system of payment incentives is needed that is expressly grounded in primary care improvement, reflects the achievement of milestones in health system management reforms, health information technology adoption, and health quality outcomes.

Beneficiaries who receive treatment from health care providers that engage in evidence-based practice should have payments augmented to support a shift toward proven practice management and clinical performance standards where preventive and chronic conditions are concerned.

In a health care safety net context, Medicaid is the principal source of revenue to examine. At the same time, there is very little evidence regarding the adequacy of primary care compensation among private insurers and health plans. We believe that as part of health reform, significantly greater focus should be placed on the extent to which in their compensation arrangements, private insurers and plans are emphasizing payments for quality and in the most cost-effective settings.

6. Invest in the development of a primary care workforce.

Investment in funding to support the education and training of a primary health care workforce covering medicine, nursing, dentistry, mental health, and other primary and community service specialties is essential. Training and education programs also need to be linked to primary care sites in order to foster the growth of skills in primary care settings, particularly settings that are located in urban and rural shortage areas and on which the state's medically underserved residents depend.

7. Make active engagement in primary care systems a hallmark of hospital and nursing facility right-sizing measurement.

The modern concept of primary health care has expanded far beyond its roots as a source of preventive services. Primary care settings, in partnership with empowered patients and communities, are meant to function as the center of health care, the key health care location for maintaining health, and promoting appropriate management of chronic and serious illnesses and conditions in the most community-oriented setting and in the most cost-efficient fashion. In order to function well, primary care providers must be integrated with hospitals and long term care facilities, as well as with sources of specialty care. This does not mean corporate restructuring. It means the development of practice arrangements that ensure that primary care providers can secure the resources and supports needed for patients whose health conditions may require specialty, referral, and inpatient care. It also means close collaboration between

institutional care facilities as patients are discharged into community settings. Recent studies suggest that primary care providers, especially those serving a large volume of lower income patients, experience significant barriers to securing the resources their patients need, either because of the lack of affiliation arrangements, the lack of financial capabilities sufficient to meet the high cost of referral care, and sometimes low participation in Medicaid among specialists. (This is especially true for dental services.)

As the state contemplates the right size for its hospital system, we believe that a key focus of inquiry should be the extent to which hospitals in various regions of the state are active participants in primary care-centered systems of care. Do hospitals actively seek out affiliation with the primary health care safety-net providers in their communities? Are referral arrangements possible, with subsidies for lower income patients who are uninsured or under-insured? Do affiliated specialists participate in Medicaid and accept referrals from primary health care providers, particularly the safety net? Does collaboration include both services designed to maintain patient health and in the community, and active efforts to ensure smooth re-entry of patients into the community following hospital discharge? Do residency and health professions training programs maintain sites in community settings?

Where hospitals compete for services to insured patients, the care of the uninsured should be “off of the table”. Competing systems should be able to set competition aside when it comes for care for the less fortunate and jointly work to improve their care.

These and other measures of “primary care engagement” should serve as cornerstones of “right-sizing” the state health care system.

Brief Conclusion

Health reform in Iowa, as elsewhere, is best positioned to succeed when the elements of reform are viewed as a series of intimately related tasks along a broader continuum. If the state’s heavy expenditures for institutional care ever are to diminish, this transformation will happen only over time, and only if policy makers act to fundamentally realign the public’s resource investments in ways that emphasize, incentivize, and reward high quality and accessible primary care for the entire population.

These suggestions are only a beginning but can serve as a skeleton upon which to develop a total healthcare strategy, aimed particularly (but not necessarily exclusively) at our public money spent on health care.