

Letters to the Editor

Access to Care for the Uninsured

To The Editor:

We applaud your recent Forum [NC Med J 2002;63:33-60] on "Access to Care for the Uninsured."¹ The wide range of articles and commentaries approached the subject with insight and concrete suggestions. We would like to add to the discussion by bringing attention to the specific problems of the uninsured in the state of North Carolina.

In a disease management program designed for indigent patients with advanced congestive heart failure (CHF) we found that although there is a plethora of social support systems available for truly indigent patients, similar support mechanisms are less abundant and accessible for the working poor. By describing a patient history we would like to raise awareness of the economically irrational and at times morally questionable "solutions" one has to turn to in order to provide the best care for those middle-class severe CHF patients who are caught in the middle.

Our CHF clinic has been following a 46-year-old black woman with severe nonischemic cardiomyopathy and class III+ CHF for almost two years. She has profound left ventricular dilatation and systolic dysfunction with an ejection fraction of 15%. Despite the advanced CHF, the patient responded well to the usual "quintuple" drug treatment protocol. She is a single parent with three children, ages 19, 14, and 11, and she is also raising her grandchild. She used to work at an Internet service company performing low-level physical labor. Following the initial hospitalization for pulmonary edema she received extended sick leave, but because of her financial situation and family obligations she decided to return to work. From a clinical perspective she could fulfill her job requirements without much difficulty. Throughout this period she was covered by medical insurance from work, yet all her medicines had a \$20 copay per prescription. This amounted to \$100 per month, a considerable sum for a single working parent with very low income and four dependents. She therefore gradually began to take her medicines every other day and then eliminated some altogether. This resulted in repeat episodes of cardiac decompensation requiring hospitalization. Finally she quit work, filed for disability, and applied for Medicaid. After a lengthy processing period with financial hardships, more episodes of missed medications, and worsening heart failure, she eventually did receive Medicaid and SSI. The patient does not work any more, and she is fully compliant with her medications. Her clinical status has stabilized.

Frequently we have seen the self-employed blue-collar worker and the minimum-wage insured worker hardest hit because of a social safety net designed to help only the poorest of the poor. Ironically, the working poor with insurance often cannot fully benefit from having insurance coverage because of high deductibles or high copayments. The effects are especially disastrous in patients with severe chronic illnesses such as CHF where the outcome so much depends on compliance with sometimes complex medical regimens. Possible solutions for these patients include seeking financial assistance from charitable organizations, pharmaceutical manufacturers' patient assistance programs, or government assistance programs. Other solutions may involve redesigning public health policies.

Patients may try to access services of various community resources whose assistance often hinges precariously on grants and donations. If assistance is available, it is often given on a one-time basis in an attempt to distribute limited resources in a fair manner. Even drug company programs for the indigent have their drawbacks. Each pharmaceutical company operates independently with varying eligibility criteria. Some companies require patients' income, W2 forms, and cumbersome paperwork. Application forms are not standardized, and the staff time required to assist the patient in filling out the paperwork may be prohibitive in the physician's office or in the pharmacy. In addition, except for vouchers, pharmaceutical manufacturers do not advertise patient assistance programs to patients or prescribers.

From a public policy perspective, state, local, and federal policies of reimbursing healthcare systems for inpatient care of indigent patients while not providing appropriate reimbursement for much cheaper outpatient care and medication is counterintuitive and counterproductive. Noncompliance with medications leads to worsening of the condition and frequent hospitalizations, which escalates the cost of healthcare. A possible solution is to change state and federal reimbursement policies to favor intensive outpatient treatment of chronic diseases and to reward health systems that are able to keep patients out of the hospital. Nykamp and Ruggles recently demonstrated that in a group of 36 indigent patients who received medical care and prescription drugs at no cost, inpatient admissions decreased by 39.5% and outpatient visits decreased by 64%, with a cost avoidance to the hospital of \$378,183.² Perhaps a large-scale reorganization of North Carolina healthcare systems would show similar cost benefits.

Another avenue that may ameliorate this depressed financial state is through Social Security disability and Medicaid. Unfortunately, there is no short-term disability program in North Carolina that might help bridge the financial gap created when a patient has a newly diagnosed chronic condition and needs to learn how to manage the disease.

The working poor and self-employed blue-collar workers are truly caught in the middle with respect to affordable health care in North Carolina. The irony is that the patient's best "solution" to the dilemma of unaffordable prescription drug costs may be to quit his or her job in order to qualify for government assistance.

Disease management programs such as ours are cost-effective models that can help improve patient outcomes while reducing hospitalizations and overall costs.³⁻⁵ Even in our CHF Clinic, however, we constantly struggle, sometimes without success, to provide financial assistance to our underinsured patients for their much-needed medications. We believe the time has come—in North Carolina and nationwide—to find and implement humane and cost-effective mechanisms to assist those poor middle-class patients with severe chronic diseases who are "caught in the middle."

Joann Hart-Wright, RN, CCRC
Fern Paul-Avilés, MSPHarm
Diane Chan, MSW
Laszlo Littman, MD, FACC
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232-2861

To the Editor:

Dr. Robert McLelland offers a cogent and convincing case for universal access to health care (Letter; NC Med J 2002;63:177). In addition, he clearly articulates three major problems that continue to plague our nation's current healthcare situation: approximately 40 million people are uninsured; we don't know how to pay for universal access to care; and inflation in healthcare costs is rampant. Unfortunately, his suggestions for overcoming these problems, while well-intentioned, do not provide realistic operational solutions.

For instance, he suggests replacing "the profit- if not greed-driven 1200 insurers with one cost-effective insurer, namely, single-payer national health insurance for ALL of our people" as a path to universal access. However, universal access does not necessarily require a "single payer" to be effective, efficient, and affordable. In fact, "single-insurer" may not be the best way to implement universal access even when funded by Uncle Sam. Nobody would question the inherent inefficiencies of 1200 insurance companies, but many might take a skeptical view of another bureaucracy-laden government agency to administer healthcare benefits for 280 million Americans (consider how well the Federal government has done with only 40 million Medicare enrollees!). There are numerous success stories of our government providing funds for services that are administered by efficient

private commercial corporations in other industries. In fact, in our country, the government does not serve as a "single payer" or "single provider" for any of the four basic human needs: food shelter, clothing, and healthcare. We may not need 1200 health insurance companies in this country, but we certainly need more than one (especially if that one happens to be the Federal government!)

In answer to the question of how to pay for such universal access, Dr. McLelland actually identifies, unaware, the most practical and palatable solution: control costs. To simply raise taxes is disingenuous and unlikely to come to fruition anyway. Although much waste and inefficiency have been squeezed out of the healthcare sector over the past 10 years since the unprecedented rise of managed care, experts (including Dr. McLelland) agree that we are all still paying for a significant portion of "elective, if not frivolous" discretionary healthcare services. Some of this high-technology-driven care is not critical to life, limb, or function, and should properly be subject to critical review. In fact, public health leaders acknowledge that we would see more bang for the buck with increased resources focused on preventive basic healthcare instead of the marginal benefit provided by increasingly high-tech procedures. As Dr. McLelland states, "If limits are to be set, it may mean some sort of budgeting, if not rationing." Some of this budgeting might have to begin within the individual household.

Finally, it should be observed that it would cost no more to fund universal access to basic health care for those 40 million uninsured individuals in our country than what we are already currently paying to provide *crisis* medical care for these same people when the advanced stages of their illnesses force to our emergency rooms and intensive care units for prolonged hospitalizations that could have been averted with appropriate and early interventions. We are already paying for the uninsured; we just don't get a direct bill for it. We would all benefit from universal access. But don't forget that our current health insurance system is not completely broken: if 40 million Americans are uninsured, then 240 million Americans *are* insured. We can make improvements without throwing out the baby with the bath water.

Please note that the comments and opinions offered herein are my own and do not necessarily represent those of CIGNA HealthCare of North Carolina, CIGNA HealthCare, or CIGNA, Inc.

Jim Bowman, MD, MSM, FACS
Associate Medical Director
CIGNA HealthCare of North Carolina
2705 Wycliff Road
Raleigh, NC 27607

To the Editor:

Dr. David Bruton's letter [NC Med J 2002;63(2):118-20] made some very good points. I am supportive of some type of universal health coverage for the uninsured, but I think it will be a while in coming. My perspective is that of a practicing internist in a small community, still deeply interested in and concerned about our rapidly changing health care system locally, statewide and nationally. I know the good and the bad that the office-based physician faces daily; I also feel I am sensitive to the politically possible and impossible.

My particular interest is how we might prioritize health care to provide a basic health care package we can pay for. Traditionally and as originally designed, health insurance was to provide insurance coverage for disease when it occurs. Now disease prevention and aging are becoming "medicalized" and, increasingly, covered by insurance. We cannot afford a basic and essential public health care package that pays for all disease prevention and care for normal effects of aging. Unfortunately, the public—and many in the medical profession—have come to expect just that.

I have several ideas of what should *not* be included in a basic package. To name only a few that I deal with every day in my practice, we cannot pay for everyone to have "normal" cholesterols (LDL < 100), blood sugars (< 110 fasting), blood pressures (< 130/80), bones (no osteoporosis), and colons (no polyps) as currently defined by some medical authorities and paid for at great costs by insurance.

We must use evidence-based medicine to find the most appropriate answers. However, most evidence-based medicine is based on specific clinical problems, and it is difficult to apply their results in determining the cost-effectiveness of treating large population groups. Randomized clinical trials and meta-analysis studies currently involve large numbers of patients and single narrow clinical questions. If a study is statistically positive, the relative risk reduction is emphasized, exaggerating the benefit in the eyes of the public as well as many in the health professions. This frequently leads to the use of multiple drugs for the treatment of several diseases in the same patient. I question the value—and perhaps harm—of many drug combinations currently in common use. We need to be able to "tease out" which drugs are really essential and which of only borderline value. This also applies to the many absolute numbers we use to define many disease entities.

The understanding of risk has always been a difficult concept for the public as well as many health professionals to grasp. The recent US Preventive Services Task Force recommendation¹ of daily aspirin use for the *primary* prevention of cardiovascular disease illustrates the problem. The recommendation says if there are no risk factors present, the 5-year

risk will be <1% and the harm is greater than the benefit: "Don't take an aspirin each day." However, if there are 2 or more risk factors present, the benefits are >3% and the benefits will outweigh the harm: "Take an aspirin each day." These are not easy concepts. Our scientific community is much better at defining and understanding risk than in the past, but there is still big gap between the reality of what risk really means and the public's interpretation of such risk. This also holds true for many medical professionals.

Primary and secondary prevention are important concepts, which will certainly need to be incorporated into any basic, cost effective, evidenced-based health package.

Structuring a basic benefit package will be very difficult, as evidenced by past failures. Only the house of medicine is able to define the benefits to be covered. These must be prioritized by relative cost and proportional benefit to the greatest number. By definition, the plan will be very restrictive. The question for medicine is how to prioritize the benefit plan using the best of the best evidence. Input will be required from multiple medical disciplines, all using good common sense to achieve the common goal. A respected and authoritative supervising entity or commission will be required for coordination and final decisions.

If the medical profession can offer a reasonable benefit package, our politicians and the public will embrace the idea of some type of insurance coverage for the uninsured much sooner. Costs and the economy may soon force the issue. The public must be motivated to make minimal health coverage for all a political reality. What a great project for the North Carolina Institute of Medicine.

North Carolina is unique in having a quality medical publication addressing North Carolina health policy issues and traditions. The move to expand the accessibility for publication to all health delivery providers is good. There should now be better and broader coverage of the serious health policy issues facing North Carolinians.

Phillip A. Sellers, MD
Quality Healthcare Associates
705 Sixth Avenue West, Suite A
Hendersonville, NC 28739

ERRATUM

In the May/June 2002 issue of the Journal, the correct title of the article by Mayes et al is "Alcohol Ablation of the Interventricular [not *Intraventricular*] Septum in Symptomatic Patients with Hypertrophic Obstructive Cardiomyopathy." The editors regret the error.

¹Ann Intern Med 2002;136(2):161-72.