

CONCLUSION

Is Community Benefits an Important Issue for My Community?

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After looking over this workbook, you may still be unsure if pursuing community benefits is right for your community. To begin to answer this question it is helpful to think about the big picture and to take a broad look at the health system as it is today.

A. Money Facts

- Our nation spends approximately 13–14 percent of our gross domestic product (GDP) on health care. The GDP is the market value of all goods and services produced in the United States in a year. In terms of dollars, that 13–14 percent equaled **\$1.035 trillion in 1996** and **\$1.1 trillion in 1997**.⁵³
- Just to get a sense of perspective, the country with the next highest level of per capita expenditure level is Switzerland. While we spend about four thousand dollars annually per person on health care, the Swiss spend about half of that, or twenty-five hundred dollars per person.⁵⁴ In short, the United States has by far the most expensive health system in the world.
- We, the people, pay a HUGE share of that \$1.1 trillion. First, obvious public spending such as for Medicaid, Medicare, and public health facilities accounts for 46 percent of total health expenditures. (This number does not include out-of-pocket or insurance premiums that we might pay as well.)⁵⁵ There are additional hidden public costs, such as tax “subsidies” offered to employers who provide insurance to their employees. Employer payroll deductions used by employers to pay health insurance premiums are not taxable, in effect, this exclusion creates a tax subsidy for employment-based insurance. This “program” costs the public tax revenues of \$76 billion annually.⁵⁶

53. National Center for Health Statistics, *Fastats A to Z* (last modified March 22, 1999), <http://www.cdc.gov/nchswww/fastats>; John K. Iglehart, “The American Health Care System—Expenditures,” 340 *New Eng. J. Med.* 70 (January 7, 1999).

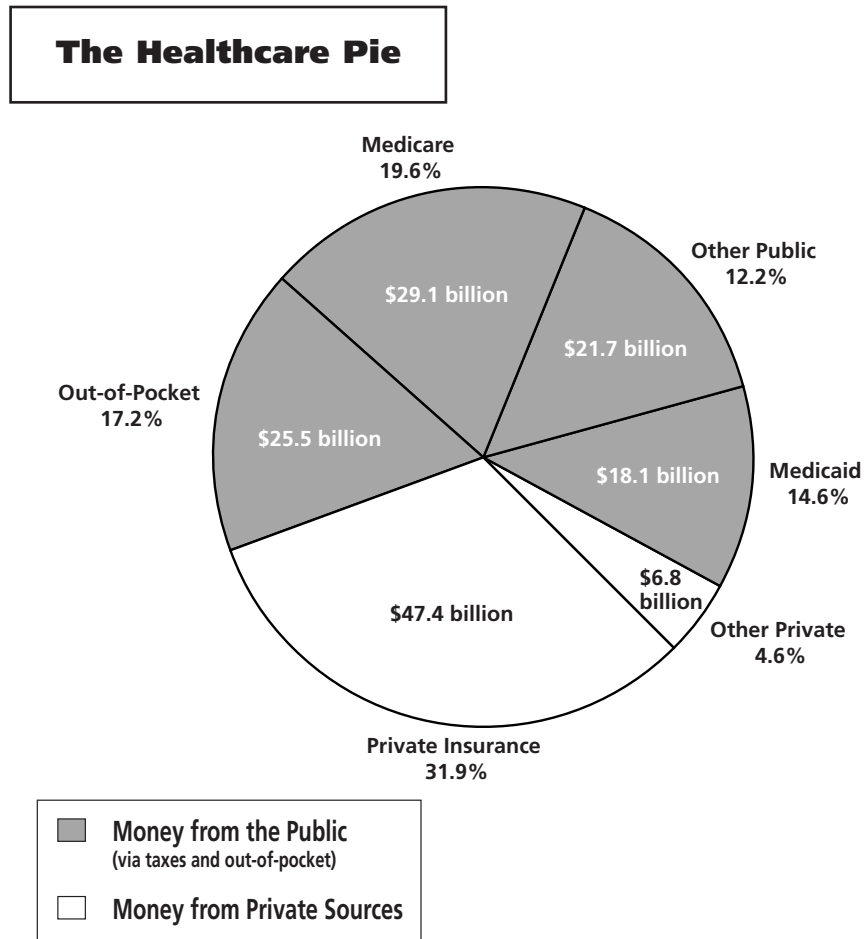
54. Marcia Angell, M.D., “The American Health Care System Revisited—A New Series” (editorial), 340 *New Eng. J. Med.* 48 (January 7, 1999).

55. See Fastats, note 53.

56. See Iglehart, note 53.

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Figure 1 Where does the money come from? WE pay the majority via taxes and our own pockets.



Based on data from "The Nation's Health Dollar, 1997: Where It Came From," Health Care Financing Administration [Office of the Actuary, National Health Statistics Group], <http://www.hcfa.gov/stats/nhe-oact/tables/chart.htm>, last modified October 29, 1998.

B. What Kind of Access and Quality Are We Really Getting for Our Money?

Even though a lot of money is flowing in today's health system, the impact of these tremendous resources is not what you might expect. Moreover, the health system is not accountable to the major payer (the public at large). Look at the following statistics pulled from a recent article in the *New England Journal of Medicine*.⁵⁷

HEALTHCARE ACCESS

- The percentage of Americans without health insurance increased from 14.2 percent in 1995 to 16.1 percent in 1997. This brought the actual number of uninsured to around 43.4 million in 1997. It is also estimated that about 71.5 million people were without insurance for some portion of 1997. Incidentally, most of these people are employed.
- These figures do not include the significant number of people who are underinsured. Those who are underinsured have insurance with high deductibles or large out-of-pocket costs, or have insurance that does not cover necessary medical treatment. The result is that underinsured people often have to choose between going untreated or having to pay extremely high costs. For example:
 - one in eight insured families without elderly members spends about 10 percent of its income on out-of-pocket healthcare costs.
 - for insured families with members who are 65 or older, 50 percent of income goes to out-of-pocket healthcare costs.
 - insured people with the most serious health problems spend about twenty-one thousand dollars a year for premiums and out-of-pocket payments.
- Approximately 15 percent of our nation's children were uninsured in 1996. In that same year, some eight hundred thousand children went to the emergency room for all their care.
- Hospital closings and service losses nationwide have had a disproportionate impact on minorities and lower-income neighborhoods, severely curtailing accessibility in these communities.⁵⁸

HEALTHCARE QUALITY

We have the most advanced health technology in the world, but does that translate to better quality?

57. Robert Kuttner, "The American Health Care System—Health Insurance Coverage," 340 *New Eng. J. Med.* 163 (January 14, 1999).

58. See Alan Sager et al., *Before It's Too Late: Why Hospital Closings Are a Problem, Not a Solution* (June 2, 1997, 2nd ed.), p. 8; Julio Mateo, Jr. and Jaime Rossi, *White Knights or Trojan Horses? A Policy and Legal Framework for Evaluating Hospital Consolidations in California* (Consumers Union West Coast Regional Office, April 1999).

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- The quality of care for minorities and the uninsured is often inferior.⁵⁹ In fact, race and sex have been found to independently influence how physicians manage chest pain.⁶⁰
- The rise of managed care and competition have caused providers to blend business decisions with medical decisions about how much and what kind of medical services should be available to patients. Where should the line be drawn?
- Nurses and physician assistants are doing jobs that doctors once performed; nurses' aides and assistants are performing jobs that used to belong to nurses—all in the name of lowering cost. How does this affect quality of care? How does it impact on the increase in medical mistakes?
- The number of specialty hospitals, specialty physicians, and specialty treatments continues to rise and the line between insurers and providers continues to blur. Are we moving toward more coordinated health services, or are we moving toward a more fragmented system?

C. So Where Does the Money Go? Prescription Drugs as a Case Study

It may be helpful to examine one of the many segments of the healthcare marketplace to understand why access and quality have not increased even though we are spending so much money. A few facts about the pharmaceutical industry reveal some of the reasons why exorbitant health spending doesn't seem to relate to the access and quality we have.

- Drug companies and pharmaceuticals represent the fastest growing segment of the healthcare industry.⁶¹ It was projected that drug companies would spend an estimated \$1.3 billion dollars on consumer advertising in 1998.⁶² We have all seen the ads for Claritin, Viagra, and other brand-name drugs. This level of spending (projected to be a 50 percent increase over previous years) follows an advertising increase of 42 percent between 1996 and 1997.⁶³ The Food and Drug Administration loosened the restrictions for advertising drugs on television in August 1997. Since that time, there has been a marked increase in the number of commercials advertising prescription drugs. These new drugs are almost exclusively high-cost brand-name drugs, which often are out of reach for the poor and uninsured. Doctors

59. See Karen Scott Collins et al., *U.S. Minority Health: A Chartbook* (The Commonwealth Fund, May 14, 1999).

60. Kevin A. Schulman et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization" (special article), 340 *New Eng. J. Med.* 618 (February 25, 1999).

61. Katharine Levit et al., "National Health Expenditures in 1997: More Slow Growth," 17 *Health Affairs* 99,101 (November/December 1998); Iglehart, note 53.

62. Levit at 105.

63. American Healthline, *Trends & Timelines—Direct-to-Consumer Ads: FDA Rules Create Ad Bonanza* (August 8, 1998).

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charge that such advertising distorts the traditional doctor-patient relationship by inducing patients to want drugs that they do not need;⁶⁴ in fact, a recent survey found that the primary source of information for clients who requested drugs was not a physician or other provider, but direct-to-consumer ads such as television and magazine advertisements.⁶⁵

- Nationwide healthcare expenditures for research and development of new technology have increased from 42 percent to 52 percent over the last decade, largely because of increased research and development spending by drug companies. At the same time the number of uninsured continues to grow, but resources for this issue remain stagnant.⁶⁶
- Even with all the money flowing, the drug industry continues to resist changes to the Medicare program that would add drug coverage and allow the federal government the purchasing power to buy discounted drugs.⁶⁷
- Meanwhile, over nineteen million elderly people or about half of all Medicare enrollees have no drug coverage. Our elderly spend more for drugs (34 percent of all health expenditures by the elderly) than for either hospital or physician care.⁶⁸
- For those who do have drug coverage (either through Medi-gap insurance, Medicaid, or an employer-sponsored plan), benefits available to the enrollee decrease as the price of drugs continues to rise.⁶⁹

64. Ibid.

65. Ibid.

66. Ibid.

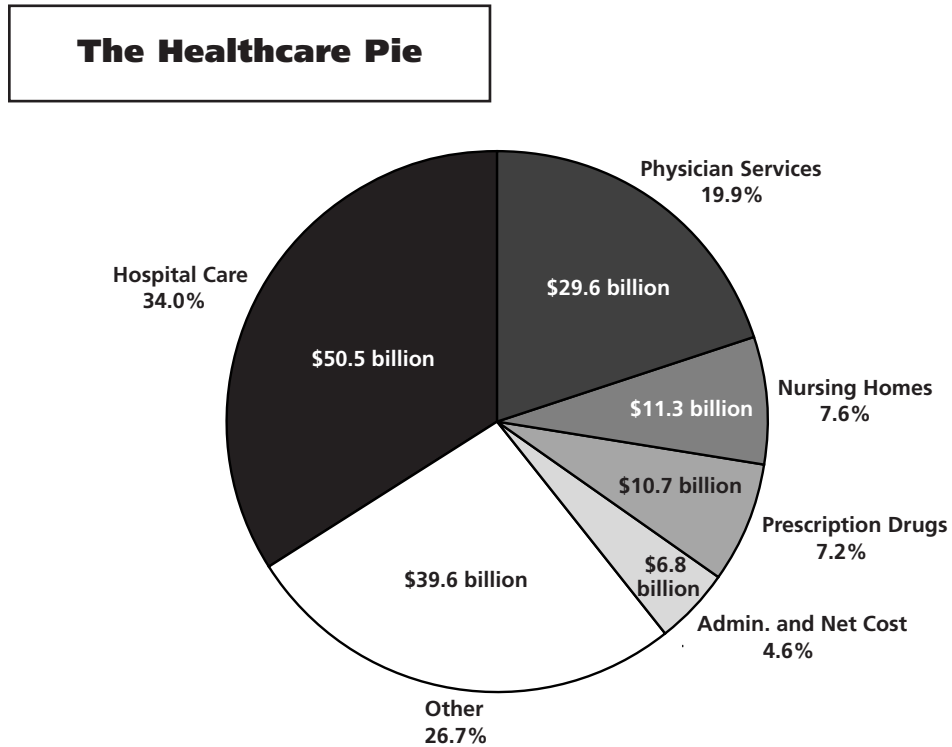
67. See Iglehart, note 53 above.

68. See Kuttner, note 57, above.

69. Ibid.

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Figure 2 Where does the money go? The majority goes for caring for us when we are sick.



"Other" includes:
dental services
other professional services
home health
durable medical products
over-the-counter medicines & sundries
public health
research
construction

Source: Data from "The Nation's Health Dollar 1997: Where It Went," Health Care Financing Administration [Office of the Actuary, National Health Statistics Group], <http://www.hcfa.gov/stats/nhe-oact/tables/chart.htm>, last modified October 29, 1998.

Note: Some costs or expenses are not included in this chart such as drug company advertising and research and development and benefits such as Women, Infants, and Children programs.

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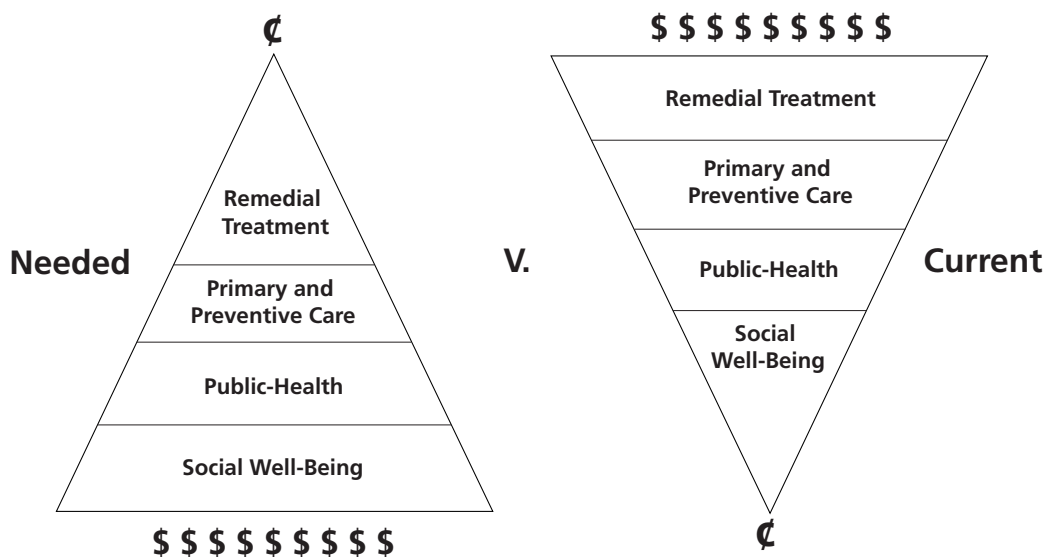
Now, take a look back at your list of what it takes to be healthy on page 4. Your list might look something like this:

- prevention
- language and culturally appropriate care
- good food and proper nutrition
- good communication between doctors and patients
- clean environment
- less crime
- peace of mind
- exercise
- outreach and education

D. The Mismatch

There is a mismatch between the amount of money we spend and the access and quality we as a society receive. There is also a mismatch between what we need to be healthy and how resources are allocated. Compare the “good health list” with the statistics in the healthcare pie on the previous page. Is our health system addressing the issues that we believe make us healthy?

Figure 3 The Healthcare System We Need Versus Today's Healthcare System



Source: Community Catalyst, Boston at Risk 2000, *Six Principles for a New Health Care System: A Blueprint for Action* (October 1994).

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It is important to highlight these disconnects as your group considers the importance of community benefits work. As we noted at the beginning of this workbook, community involvement in healthcare decisionmaking is critical to protect free care and other safety net services as health care continues to change. But perhaps more importantly, community benefits can also be an effective step for your group to bring about deeper change and address the discrepancy between what is needed for good health and the way that health dollars are actually spent. Community leaders may be the missing consumer voice that demands quality and shapes the content of care. Community leaders can work to influence where hospitals are located and the services they provide. Consumers should monitor the changing role of the doctor in today's managed care world. Communities need to reevaluate the role of and establish relationships with local health institutions to improve the delivery of care to our communities. In the long term, your group may seek a broader role for grassroots leaders in governing local institutions, setting priorities, and in the allocation of health dollars overall.

After reading this workbook, you will hopefully agree that organizing around community benefits issues can improve health care in your community by:

- creating communication and dialogue between grassroots leaders and institutional and other health resource decisionmakers to ensure collaboration around identifying problems, crafting solutions, and selecting priorities;
- increasing access to appropriate and respectful health care for those most in need in our communities;
- making more efficient use of existing resources to keep people, especially vulnerable populations, healthy;
- increasing participation by diverse institutions as well as more traditional community benefits providers in community benefits processes and community dialogue;
- involving everyone (industry, government, and the people) in changing the dynamics and making a health system that really is about keeping us healthy!

We hope that this workbook has been a helpful resource in your community's efforts to improve your local health system.