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THE PRESCRIPTION FOR GOOD HEALTH MAY NOT BE FOUND IN ACCESS TO THE HEALTH CARE SYSTEM

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ABSTRACT

A large number of our policy makers are focusing on the millions of Americans without health insurance as the major health care problem in this country. Their solution to the growing problem of access to the health care system is some form of national health insurance for all Americans.

This paper questions whether the real problem in our health care system is really an issue of access or a desire for good health. If it is an issue of a desire for good health then access alone is not the real problem. Access to health care services in itself does not guarantee good health.

Good health can generally be obtained and preserved by practicing good health habits. If one is healthy, the access problem becomes less of an issue for most Americans. Lack of information concerning good health behaviors and the direction of health care resources towards this end becomes the most significant health care problem, not access.

INTRODUCTION

A large number of our policy makers are focusing on the millions of Americans without health insurance as the major health care problem in this country. Their solution to the growing problem of access to the health care system is some form of national health insurance for all Americans.

According to Cohen, Chavez, and Chehimi (2007) the contribution of medical care to good health is not that strong. In fact, Blum (1981) found that environmental forces and lifestyle choices are much greater contributors to good health than clinical care. In a similar vein, Woolf, Johnson, et al. (2007) argue that investments in medical advances may not save nearly as many lives as investing in social policies to equalize the education disparities that are associated with high mortality rates among less educated adults. This further supports the argument that providing access to health care services to all Americans will not necessarily improve the health status of Americans to any great extent.

The current debate about whether health care services should be delivered by the market or by the government is never going to provide solutions to the health care problems in our country.

It will fail because it is asking the wrong question. The question needs to focus on how do we remain healthy and free of chronic diseases not how do we finance free health care for everyone even if they don't want it.

EPIDEMIC OF CHRONIC DISEASES

According to the Center for Disease Control (CDC) (2007) those diseases contributing to the greatest morbidity, mortality and disability in this country have become the chronic diseases. Cardiovascular disease, cancer and diabetes are the most prevalent, costly and preventable. The CDC (2007) argues that seven out of ten Americans, who die each year, die as a result of a chronic disease.

The only way to prevent chronic diseases and their complications is through health education programs. These educational programs are not hard to develop but offer tremendous challenges in program evaluation. There is a need for a different type of evaluation process for health promotion programs whose goal is the reduction in their burden from chronic diseases in the country.

Chronic diseases generally have a long incubation period and are caused by multiple factors. These causative factors complicate the program development process making evaluation of program success or failure extremely difficult.

The payoff for reducing the incidence of chronic diseases in this country is enormous. The CDC (2007) points out that the medical costs for individuals with chronic diseases accounts for seventy-five percent of the total health care costs in the country. More important than the monetary costs of these diseases is the years of potential life lost for people under the age of sixty five.

THE NEED FOR A PRIMARY PREVENTION MODEL

It should be understood, of course, that we do not question the value of various efforts to expand health care access to all who need it, nor do we intend to suggest that health care access is not itself often a necessary component of many preventative health measures. Preventative health – even as delivered through existing health care systems – is not necessarily expensive; however, the most cost-effective prevention measures may occur outside of the health care system.

This is where a model of primary prevention comes into play. If we prevent poor health for the majority of Americans we do not have to construct an elaborate Federal response to the access issue in America. As poor health diminishes as a problem, universal health care becomes both a less pressing problem and a potentially less costly potential endeavor, in that general health will be improved and thus health care costs will decline.

According to Cohen et al. (2007) primary prevention requires action before a problem occurs in order to entirely avoid the problem. There is no reason for American businessmen to look at prevention as an afterthought. It just makes sense that to reduce the incidence of health problems, especially costly chronic diseases; the company has to rely heavily on proactive steps with employees that involve primary prevention.

Despite the enormous volume of success stories that result from primary prevention efforts there has always been a reluctance by the majority to embrace primary prevention as the model of health care delivery for this country. It may be a result of greed by medical professionals, apathy

by elected officials or ignorance by consumers but the nation usually deals with health problems "upstream" after they have happened and the damage is done. It is now time for all the players in health care delivery, including employers and employees, to embrace primary prevention as the health delivery model, especially in the workplace. The economic incentives are all in place to make this revolution happen now.

Prevention is probably our only hope for reducing unnecessary and wasteful demand on our health care system. It stands to reason that as a nation we will not be demanding expensive medical care interventions if we do not practice the behaviors that have been proven to cause the health problems that require these medical interventions.

ACHIEVEMENT OF GOOD HEALTH FOR THE DISPARATE POPULATION

In one respect, an intellectual position of prioritizing prevention over access may appear to be elitist, in that the burden of poor health is disproportionately concentrated amongst those who do not have access. It could be argued, for instance, that preventative care is a luxury afforded only to those who are already privileged in the health care system; much necessary preventative health measures are not undertaken among low income, minority, and foreign born populations because these are precisely the populations who are more likely to be uninsured, and thus unable to avail themselves of routine, non-emergency medical care (National Center for Health Statistics, 2006).

However, there are two important points to be made with regards to this position. First, it is among the disadvantaged groups in the health care universe who are more likely to engage in most health risk behaviors. With the exception of alcohol, which is most commonly used by higher-income individuals, drug and tobacco use are more prevalent among lower income, minority, and foreign-born populations. These groups also tend to have lower rates of physical activity and higher consumption of fat as a proportion of all calories (Berrigan, Dodd, et al., 2003; Diehr, Loepsell, et al., 1993). Although occupational and community wellness programs may be more prevalent in upper-income jobs and communities, due to greater funding capacities and public support, the greatest improvements in health status from preventative health programs would most likely be realized among the disadvantaged populations, who are less likely to practice good health behaviors to begin with.

Second, because disadvantaged populations are less likely to have health care access, they are less likely to receive preventative health care and education through routine visits with primary health care providers, which means that easily preventable chronic conditions may go undetected and unresolved until they become serious, potentially life-threatening, and extremely costly. Many of these chronic conditions could be easily averted if individuals had better access to health information on the job and in the community. Although health care access can do much to reduce health disparities, it is not necessarily the most cost-effective first step to better health for disadvantaged populations.

Cohen et al. (2007) argues that there needs to be a holistic approach used when policymakers are attempting to eliminate health disparities. They need to go past the access issue and look at medical resource availability, where people live, their total environment and most important, consider the individuals knowledge about consuming health care. Again, access to health care does not guarantee timely and proper use of health care services, nor does lack of access necessarily

preclude the adoption of good health behaviors among disparate populations through a community-based prevention model.

THE WAY TO FINANCE HIGH-RISK HEALTH BEHAVIORS

Feldstein (2003) argues that individuals buy health insurance to get rid of uncertainty by spreading the risk among a large number of individuals through a pooling of health risk thus lowering the cost of premiums for those participating.

More and more employers are asking whether they can afford health insurance for their employees and is this health insurance worth what it costs. The cost of the insurance does not seem to be as important as the fact that the current health care delivery system is plagued by failures in preventing the development of expensive chronic diseases in the insured population.

The health care system must face radical change in the next few years or the best health care delivery system in the world will go broke. This sounds very similar to the crisis we face in Social Security over the next several years. Busbin and Campbell (1990) argue that health insurance costs are rising at such a rapid rate that if not stopped will eliminate all profits for the average Fortune 500 company in the next several years. It seems like an opportune time for employee wellness programs to be considered by employers as a potential solution to the crisis.

Insurance is generally classified as casualty or social insurance. Casualty insurance is found in car or home insurance and has worked very well as long as most people practice safety measures concerning automobile and home use. Social insurance usually ignores risks and shares the costs equally among participants. Enthoven and Fuchs (2006) argue that a change from the concept of social insurance where excess costs of high-risk behaviors are shared collectively to health insurance based on actuarial principles where the price for insurance is based on predictable risky behaviors undertaken by some individuals is going to be the norm. In other words, you will be charged a higher premium for health insurance if you practice high-risk health behaviors.

DISCUSSION

It seems that every political season, especially during the Presidential primaries, that the politicians and the media bombard us with the problem of access to health care services as the major problem for our health care system in this country. We are told that over forty seven million Americans are without health insurance and that the only answer is some form of universal health insurance coverage for everyone in the country.

This may be the wrong question to be asking and therefore, the solution may be entirely inappropriate. It is not insurance or lack of insurance that forces us to consume too many calories and alcohol, use tobacco or decide to not be physically active. Insurance coverage will not stop Americans from practicing these high risk health behaviors. Once individuals develop chronic diseases, even though insurance can help them get better, they will probably become ill again if the bad behaviors don't stop. Although health care providers have an important role in educating about and encouraging good health behaviors, their intervention is a last resort, not the starting point.

The question that needs to be posed by politicians and the media is "How do we get individuals to appropriate preventive medical services in time to prevent the very expensive chronic

diseases to develop? This is a much more difficult question that requires much more consideration and a different response than simple access.

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HEALTH CARE LEADERSHIP'S ENERGIZING ACTUATORS: PERCEPTIONS ACROSS WORKER GROUPS

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ABSTRACT

This paper describes research performed on health care worker perceptions of eighteen specific behaviors leaders use to motivate or energize employees. It is a comparative study assessing the ranking differences among three specific worker groups: mangers, administrators and supervisors; knowledge worker licensed professionals; and support personnel such as technicians, clerks and computer operators. Statistically significant differences among the groups were found. Research findings are presented and analyzed along with a literature review of theorized explanations for the discovered results.

WHEN THE FORCES OF INDUSTRY CONFLICT WITH THE PUBLIC HEALTH: A FREE MARKET MALIGNANCY

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ABSTRACT

This paper is the third in a series focusing on the unhealthy propinquity between industry and infirmity. It frames a growing discussion around the dilemma of business interests whose fortunes are tied to a continuation of -- rather than the elimination of -- common human ailments and disease. Hence we face a malignant paradox: If the public health were to markedly improve, multiple billion-dollar industries would suffer. And that is an unlikely near-term expectation, given the marketing and media clout of the affected industries.

Instead of receiving reliable and objective information to help improve health and fitness, consumers will continue to hear the message that keeps the "infirmity industries" thriving: that physical ailments are normal, that physical ailments are unavoidable, and that relief is available for purchase in the drugstore, at the doctor's office, or on the operating table. The malignant paradox can be stated another way: There is no money in good health. And in an untrammeled free market, money trumps health.