Caring for the Poor

Jerry A. Morris, Jr., Psy.D., MBA, ABPP

Clinical Director

CMHC, Inc

Nevada, MO 64772

Abstract

Psychologists in the private practice of primary psychology are faced with community and hospital requests that they care for the poor who are covered by the Medicaid system or who are indigent. The American Psychological Association has developed a resolution which makes it clear that psychologists have a responsibility to assist society in dealing with the mental health problems of the poor (American Psychological Association, 2000). Many states faced with growing budget deficits, emergent philosophies which view health care expenditures for the poor and disabled as out of control, and with changes of legislative priorities are cutting or eliminating Medicaid health care services for the poor and disabled. Missouri is an example state in this regard and the issues in Missouri are instructive concerning the style, nature, and issues related to the planning process for cuts and their impact on practitioners and health care facilities across the country.

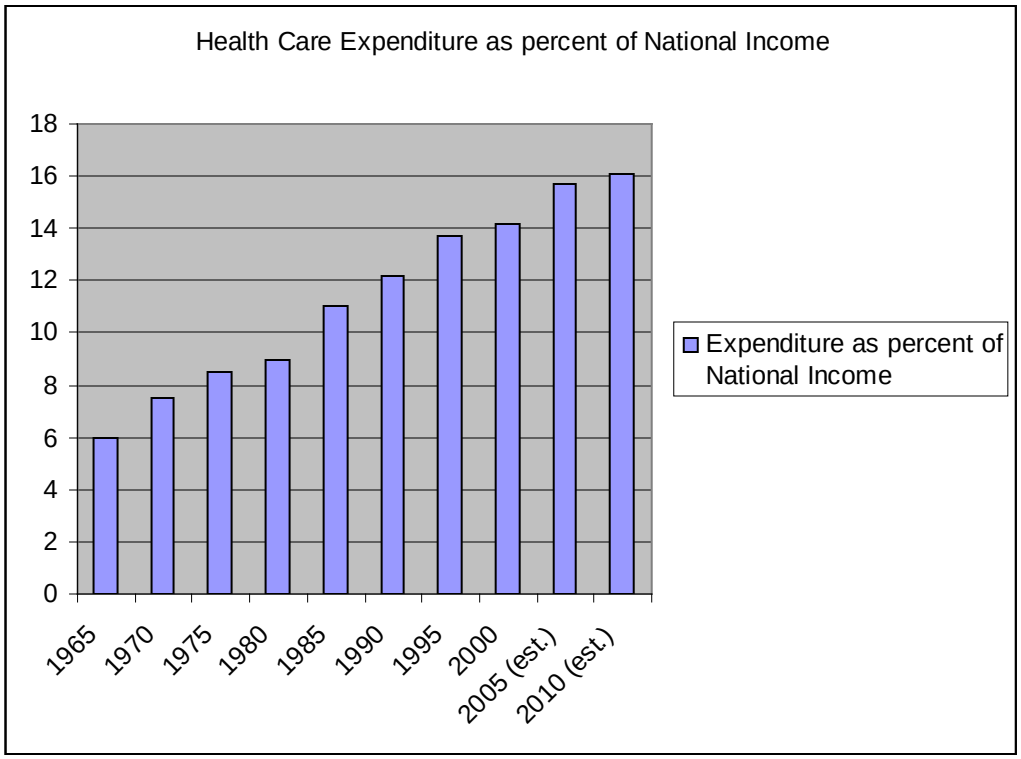
This article points out the importance of comprehensive and long-term planning. Such planning must be done within an approach that has a substantive understanding of the positive and negative effects of cutting health care services for the poor. Further, such cuts are viewed in the greater context of the cost and inflation drivers at the core of increasing health care expenditures and historical attempts to curtail costs without addressing core cost drivers. The point is made that increasing barriers to access to services, decreasing the absolute number of covered poor, and cutting Medicaid budgets will not make the needy disappear, but will merely shift costs and begat unanticipated costs and consequences.

Caring for the Poor

The Reform Motive

Missouri is similar to many states with regard to the growing motive by legislatures reconstituted under new leadership philosophies to cut Medicaid programs and curtail the inflationary pressure in healthcare for the poor. Missouri, often a political bell weather state, may also be a good barometer of the level to which the analysis of the problem, rhetoric, and solutions. Some have become impressed with several trends related to health care expenditures for the poor and disabled since 1967 when the state of Missouri Medicaid system was devised. This article will use Missouri and its' struggle to define Medicaid inflationary drivers; the efforts to devise a careful analysis of situations, options, and consequences; and to devise a rational plan to address the health care needs of the poor while curtailing Medicaid inflation.

First, and possibly foremost, the growth of national public healthcare programs from 5% of the Gross Domestic Product (GDP) to 15% of GDP (Missouri Medicaid Reform Commission, 2005a) has caused some to shudder. The percentage of total national income spent on health care in the United States has risen substantially (Miller 2004, p. 737):



This trend, indicating health care expenditures of increasing portions of national income has alarmed some who see this as excessive or ill-advised investment which is growing at an out of control rate.

The President of the United States, in The Annual Report of the Council of Economic Advisers indicated that one of his top second term goals is to ensure that there is affordable and accessible health care for American families (Economic Report of the President, 2005, p. 7). Yet, today more people are without health care coverage, are poor, or on the verge of slipping into poverty, and disabled than at any time in US history. Additionally, states are being pushed by budget cost shifts from the federal government (cuts of federal program supports which result in pressure on states to fund the cuts or severely restrict or ration care) to cover more and more of the financial responsibility for these programs. Often, the state's solution is to cut Medicaid and other social programs, education benefits and programs (accrued largely to the poor), and Government transfers

(food supplements, transportation, assistance with home making for the disabled, childcare subsidies, etc.). These programs for the poor are viewed as "too costly", "out of control", and "wasteful" by some. Others think of them as "essential", "components of the Great Society that make America a modern and progressive nation", and "good investments in human resources and the future of families which prevent long-run costs"! One view sees the poor as individuals of underdeveloped or deficient character who are consuming unnecessarily excessive amounts of resources in an economic death spiral toward disaster. Another view sees those in poverty, or soon to be there, as victims of contextual factors that are difficult to overcome and which leave the country vulnerable to deterioration, social unrest, and increasing economic drain on the economy as a whole (Rank, 2005). The first view ("defective character and ability") would handle health care for all one way, and the second view ("human resource and workforce development") would handle it another! This great divide and bifurcated vision sets the stage for the emerging identity of the USA that will go forward into the next generation.

Some in this debate focus only on total national investment for health care for the poor, and don't integrate the return on health care investment as a growth factor in the GDP and national well being. Viewing this investment this way ignores the fact that there are appreciable and valuable returns on health care investment! It also discounts the fact that the health care industry is servicing one of the largest consumer needs and wants (e.g., health care, and indeed citizen health is a high demand item fostering a growth industry which would naturally be expected to expand). Consumers value health above most other purchasable commodities.

With advances in research, diagnostic capacity, and interventions consumers are aware that "you can purchase health and longevity"! They have come to see the denial of access to health care services as a fundamental infringement on rights and fairness. These attitudes toward health care make rationing or denial of health care an untenable solution with limited and factionated political support. Consumers want to spend a sizable portion of GDP on health! In a market economy and democratic society where consumers vote with their dollars and based on their perceived (consumer tastes and preferences) as well as codified rights, the psychology of the public makes denial of health care and rationing difficult to sell politically!

Even managed care approaches to rationing attempt to disguise this technique under umbrella rubrics such as "waste, fraud, and abuse prevention", "lack of coordination and supervision of practitioners", "use of unproven interventions"! As the public becomes more aware of "misleading language" which obscures that rationing is occurring (Miller, 1996a, p. 577). When the courts have exposed the underlying techniques of managed care related to placing financial barriers to access to services and specialists, phantom panels, lack of maintenance of sufficient assets to pay for psychologically/medically necessary care, and loop holes which exempt plans from accountability, a rationing approach is clearly indicated and made transparent (Holloway, 2004). As this occurred a situation identified as "invisible rationing" (Miller, 1996b, p. 583) occurs and public opposition to managed care approaches and to health care planners and legislators advocating them has mounted.

If the well-off are viewed as "deserving of health and longevity", and the poor are viewed as "negligent, deficient, and of low character and undeserving", then the

conclusion that the poor should pay for their own health care rather than receiving it through Government programs emerges. This view is akin to the view that that "poverty is the result of bad character and that the poor are unmotivated" and therefore the help for the poor should be cut"! Such a view has led to increased poverty, disenchantment, expensive side effects and unanticipated consequences, and erosion of the middle class as they are forced to pay for mistakes around poverty management (Rank, 2005)! Certainly, psychologists have struggled with negative attitudes toward the poor and rationalizing that they could not use or will not effectively use services (Smith, 2005). These attitudes have acted as barriers to providing adequate research, problem analysis, program development, and treatment of the poor. In some economists view, the result is mismanagement of human resources and a failure to invest in the future workforce and economic growth! Out of this "low character view" 13 to 15% of GDP is just too large an investment to make for poor people's health. In this view, health care investments are not evaluated in the frame of the balance between total expenditures and their return for the economy, economic growth produced, human potential and well being, and productivity (Fox, 2005, p 5).

Rather, the total expenditures are evaluated in a linear fashion with regard to their perceived crowding out of other national investments and higher priorities. The health care expenditures for the poor are not viewed as a legitimate exercise of the redistribution of wealth (an important function of free market Governments in order to maintain a strong economy, fight unrest and the negative consequences associated with inequality and lack of opportunity, and an important investment in the future and expandable workforce). From the "poor character" point of view health care expenditures of 15% of

GDP are a horrible thing, a waste of important resources, and a luxury expense rather than a rational investment investment. Those holding this latter view believe that those who support the current level of expenditures of health care services for the poor are motivated out of strictly humanistic values ("bleeding hearts") and they have difficulty integrating the economic, social, and political advantages of affectively satisfying top consumer priorities, providing vehicles and opportunities for the poor to enter and advance in the labor source, extending the longevity and productivity and consumption years of the poor, and economically and politically avoiding the consequences of social unrest and desparate acting out.

Of course the "human resource and development view" holds that a successful health care industry that is growing, delivering more longevity and health, is valued by consumers (growing demand), and contributes to national productivity, workforce expansion and development, and to the psychological well being of society. This view posits that, a high demand product that is affectively and efficiently being delivered to the market, in a growth industry, in an expanding economy, that is addressing income inadequacy and redistrubition of wealth, is an industry to celebrate. The expansion of such an industry is estimated to be a success, and according to the consumer sovereignty point of view is highly democratic, is an artifact of the "invisible hand" (Smith, 1776) that creates efficiency in free markets and Capitalism, and that the phenomenon of industry expansion represents the free market reward for suppliers and consumers. From this point of view and efficient industry that is growing because of valued products and much consumer support merits support. In this view, politicians and planners that seek to thwart the growth of the health care industry and reallocate resources to lower consumer

priorities will be viewed as out of touch at best and enemies of consumer sovereignty at worst.

Of course, the “poor character” and “waste and excess” point of view would argue that Government programs such as Medicaid are not free market programs and therefore can’t be evaluated in that fashion. They would (probably without realizing it) argue that they are Command Systems (communist approaches) in which a committee has the responsibility to shepherd the taxpayer’s resources and in the spirit of good stewardship curtail spending when it is “excessive”, “wasteful”, or “inefficient”! Such an approach has merit where the core problem is waste or garish delivery of useless and ineffective services and interventions. To justify this position and the use of a Command System (presuming that Smith’s concept of liaises fare and that the free market and Capitalism will adjust demand and supply much more efficiently than Government tinkering) one would have to clearly demonstrate that most of the problem with the growing total dollars as a percent of GDP and health care inflation are a result of waste, use of unhelpful interventions, and is not appreciated (low demand) by consumers. Otherwise, most economists, Capitalists, and social scientists agree that the free markets driven by consumer sovereignty are superior to a Command System approach in the long-run (even if there are some short time horizon advantages to the Command System approach-Mankiw, 2000)

A state example from a fairly mainstream and bell weather state is appropriate here. The Missouri Legislature has set up a Missouri Medicaid Reform Commission (2005b) to establish clear policy with regard to Medicaid. The Missouri Medicaid Reform Commission (the commission) is positioned to develop an analysis and plan to

deal with the growth trend in health care costs. The commission points out that since the 1970s and 80s that healthcare inflation has moved from 4% to 7% (Missouri Medicaid Reform Commission, 2005a). Based largely on this finding and fears of budgetary exigency alone, and without in depth analysis of the nature of the components of the health care system that are driving that inflation, the Missouri legislature decided to cut Medicaid health care services for the poor, raise spend-down and co-pay patient payment levels to qualify for Medicaid (when the poor have no discretionary income by definition and in many cases will not be able to meet these investment requirements), and lowered the income levels which trigger entry into the Medicaid system to well below that of subsistence in our society and economy.

Inflation is negative when it represents empty price increases. If the increases in price result from increased technology, efficiency of production of new and valued product enhancements, and increased product effectiveness they are not "empty price increases'! This is difficult for those who are not used to economic analysis and who look at spikes in data arrays or inclining data trends over protracted time lines to understand. To put it directly, all inflation is not the same, all spikes in data arrays are not equal, and all inclining trends for expenditures are not bad. War, related to the core economic and Government function of providing security and continued private ownership or property often shows inclining total expenditure curves during the prosecution of the war and indeed during reconstruction periods post war. Is that bad? Like most things in economics and political science-it depends on your perspective!

Price increases in the health care industry are at least partially due to the industry's capacity to increasingly fund and conduct research and development, rapid

innovation, and bring needed and wanted new products on line. Thus, some of this type of inflation is functional inflation rather than empty inflation. In order to understand the meaning of health care inflation, a careful adjustment of inflationary figures for the useful inflation and the non-useful inflation would be necessary. This is especially so in highly technologically and research driven industries.

Regardless of which of the two views held, standard economic principles dictate that a careful and comprehensive analysis of the health care problem must be formulated prior to taking reform actions. However, the Missouri commission, and other states may make the same mistake, has not taken into consideration the data on economic growth created as a result of health care industry investment. Legislators can become myopic when looking at parts of the data like rises in percent of GDP, or over all health care inflation. Like the blind man who feels the elephants tail and describes a very different animal than the large and powerful beast before him, planners who make this mistake fail to make interpretive adjustments that allow for a substantive understanding of a phenomenon. Many economists point out that some look at health care only as an expenditure (Mandel, 2005) when it is actually an investment with considerable track record for return on investments and thus the creation of economic growth and benefit rather than a drag on the economy (Clement, 2002).

Economic analysis of the positive results from health care investment include the expansion of the average life expectancy from 68 years in 1950 to the current 77 years, and adds an estimated $7,000 to $220,000 per year per person in contribution to economic growth and between $600,000 to $17 million of additional contributions to the GDP per capita per lifetime (Miller, 2004, p. 741). Certainly, a linear approach to

evaluating health care expenditures by calculation of percent growth or percent of GDP is overly simplistic and economically naive! Such approaches fail to comprehend the cost benefit analysis, marginal cost/benefit, multiplier effect, consumer sovereignty and consumer priorities, and other more complex aspects of why health care expenditures have become a major portion of the current demand matrix. They fail to fathom why health care is such a vibrant growth industry that is still in the beginning stage of the industry life cycle. To label health care spending as "excessive" or "wasteful" without such substantive analysis and understanding, without adjustment of the data for positive investment and well being effects is ill advised at best, and demonstrates a lack of capacity to comprehend complex economic problems at worst!

However, regardless of the commission's attempts to frame the question as to who to short (rationing) with regard to health care - the poor, disabled, children, or the elderly; (Missouri Medicaid Reform Commission, 2005a). The real task of the Missouri Commission, and for those like it in other states, will be to identify and modify the specific components of the healthcare system that are driving cost increases rather than cutting broad slashes across the entire program.

As states look at the data, to clean up the health care system and curb the expenditure and inflation growth trends, reformers would have to take on some hefty political foes: major hospital corporations and pharmaceutical companies. Also, a legislature would have to target specific items such as rising expenditures on amelioration of heart disease, cancer, and costs associated with an expanding aged sector of our population with increased longevity (National Center for Health Statistics, 2004). If legislatures want to effectively use unpopular rationing approaches they would have to

restrict who gets expensive and sometimes short effect treatments for some for some of the most feared and deadly diseases of the heart, organs, and those which make the last weeks to months of life more functional and tolerable. These major cost drivers are so important to Americans that they may want to commit major portions of the GDP to ensuring that everyone has access to related health care.

Like the Marines, Americans may not be willing to leave their wounded and dieing on the battlefield! In a democracy and free market system, consumer sovereignty reigns, and demand is rarely controlled or contrived (for long), but rather based on consumer wants, needs, and preferences. State Governors and Legislatures will bring these aspects of democracy and economics into clear focus as they attempt to cut or ration health care without a careful and substantive analysis of the core problems in the health care system and a rational and well communicated conceptualization of the cost/benefit ramifications of their approach. Consumers have grown skeptical and increasingly sophisticated and will expect specific plans to address core rather than peripheral problems with the health care system.

Simply cutting health care services for the poor sets up a red herring argument. It implies that expenditure increases and health care inflation are driven by the provision of excessive and inefficient services to the poor and disabled. In fact, cost increases are driven by expansion of hospital costs, drug costs, and increasingly expensive treatments of specific and very prevalent disorders. The US health care delivery system has efficiently delivered increased longevity, dynamic and continuously improving technology, vital research and technique development, and improving key population health indicators. The problem cannot be spun as excessive and inefficient services to the

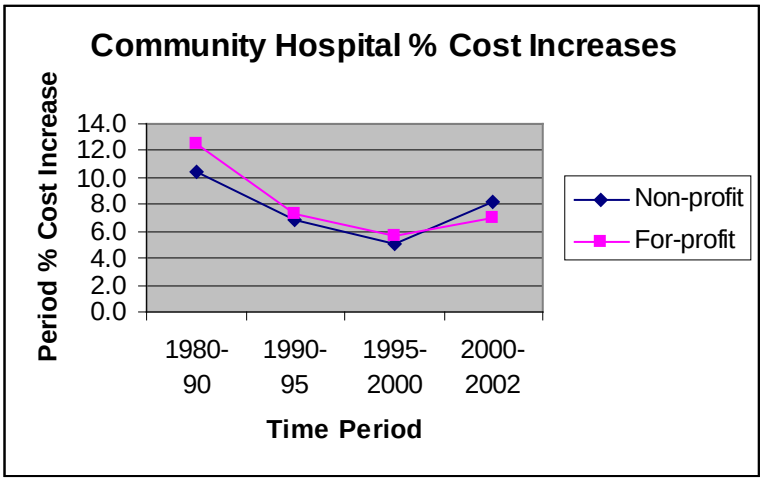
poor. A realistic effort to curb costs increases would focus on the specific expenditure and inflationary drivers and upon developing economically efficient ways to address the major illnesses consuming greater and greater portions of health care resources. To target the poor and disabled (a politically vulnerable sector of the population) and ignore hospital costs and drug costs may be a target of convenience, but does not represent a sophisticated and relevant effort at curbing growing health care costs. Such an approach will not stand scrutiny as a realistic effort at health care spending and inflation control, and will not deliver long-term results.

When a legislature announces that cost containment is their priority they either mean "we'll get some of the resources used by the poor and disabled and protect the large health care corporations" (hospitals and health care management groups and drug companies) or they mean "we have the political capital to take on the big boys and win" by focusing on the specific areas of the health care system where costs are increasing at the fastest rate and in larges total expenditures! Either way, it's a "big sell" and a "big job"! For, "they will know you by the fruits you bear" (if you cut healthcare for the poor and large health care corporations get richer, you've simultaneously succeeded with your contributors, and failed with voters-the observant middle class being the tie breaker).

Getting Under the Hood

According the United States Department of Health and Human Services, Agency on Healthcare Research and Policy we have the research needed to understand the targets for controlling health care costs. In general there are two of the major components which are driving increases in health care costs: increases in medication costs (Kreling, & Hanley, 2001), and increases in hospital costs (National Center for Health Statistics,

2004). In 2002 hospital costs accounted for 31% of all health care expenditures, and medication costs were another 11%. Hospital costs increased at an average annual rate of 9.8% from 1980-1990, 6.4% from 1990-1995, 4.3% from 1995-2000, and 8.1% from 2000-2002 (National Center for Health Statistics, 2004, p. 359). Small hospitals (6-24 beds) increased costs at 21.1% between 2000 and 2002. Total hospital expenditures in the US in 1980 were $91.9 billion, and in 2002 they were $462.2 billion, a 500% increase, (National Center for Health Statistics, 2004, p. 359). Interestingly, nonprofit community hospitals showed very little difference in cost increases compared to for-profit hospitals during that same period. In other words, even when the public gives tax breaks, federal and state grants, the ability to tap into donations and philanthropic funds, at least theoretical avoidance of distributing wealth and profits to shareholders, and government based discounts, training, and perquisites (huge costs to the public), there is no significantly increased efficiency gleaned from non-profit hospitals.



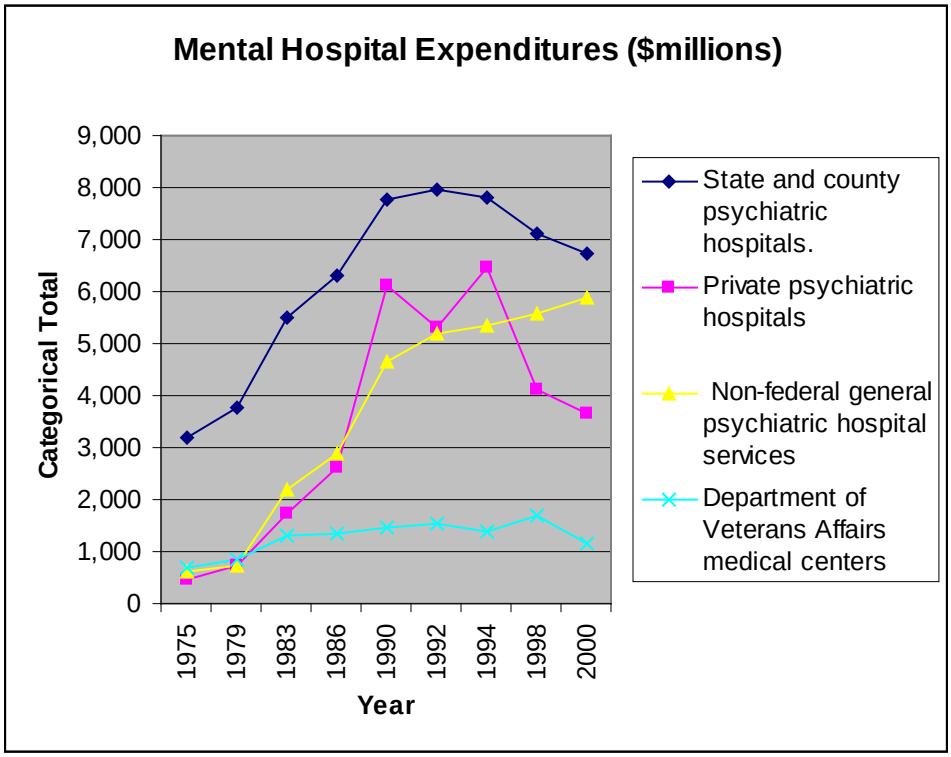
Therefore, with regard to community hospitals, whether the institution is a non-profit or for-profit (tax paying) hospital make little difference with regard to cost and inflation containment (National Center for Health Statistics, 2004, p. 359). In fact, in the

most recent data era, for-profit community hospitals have experienced slightly lower cost increments than non-profits. During the most recent reporting period (2000-2002) community hospital expenses increased at an average annual rate of 8% compared to the 5% average annual rate of increase between the previous reporting (1995-2000).

When the data on mental hospitals, as opposed to all hospitals in general, is reviewed, it is easy to see that psychiatric hospitals have pretty well contained, or decreased, total expenditures since 1990 (National Center for Health Statistics, 2004, p. 361). Expenditures for state and county psychiatric hospitals leveled off in about 1990-92, and have decreased appreciably since that time. Expenditures for private psychiatric hospitals leveled off from 1990-94 and have dramatically decreased since that period. This decrease in private sector expenditures has occurred even though the psychiatric hospital support from state and federal hospitals has declined placing increasing burden on the private sector to take care of the most severely disturbed, and expensive to treat, patients. Veteran's medical center mental hospitals have demonstrated basically flat expenditures since 1983.

The one sub type of mental hospital where there are significant increases in expenditures is the non-federal psychiatric hospitals where there has been a steady inclining trend since 1975. Clearly, the increases in national hospital costs are not related to mental hospital cost drivers, with the possible exception of general hospital psychiatric units. The psychiatric hospital segment of the mental health industry has responded to the cost and inflation problem by curtailing expenditures on psychiatric hospitalization, curtailing the increasing expenditure trends for state and federal psychiatric hospitals, and shouldering the burden for decreased federal and state increases to cover heavy demand.

A graphic display of these trends is shown below.



These data are affected by declining community hospital beds for mental patients between 1990 and 2002 (National Center for Health Statistics, 2004, p 33). Between 1990 and 2000 the number of inpatient mental health beds declined 31% with the largest attrition occurring in state and county mental hospitals and private psychiatric hospitals (each with almost a 50% decrease). Thus, a case can be made that the mental hospital industry has made adjustments during the last 20 years to successfully curtail total expenditures by cutting beds and curtailing growth. This part of the overall national hospital industry is not contributing meaningfully to cost increases in health care in recent years. The one exception that is worthy of note and possible attention is cost increases related to psychiatric beds provided in general (usually non-profit) hospitals.

It should be noted that general hospitals (even those with psychiatric units) are the hospital settings where the poorest diagnosis and treatment of mental patients is accomplished (Morris, 1997; Kroneke, & Mangelsdorf, 1989; Kunen, Niederhauser, Smith, Morris, & Marx, 2005). In these settings most mental patients are evaluated and treated by general medical personnel who are not psychologists and psychiatrists. The poor are increasingly forced into emergency rooms for mental health care due to the lack of availability of specialized personnel in outpatient settings and lack of funding for mental health care, access barriers due to poverty, (National Center for Health Statistics, 2004, p 35). Minorities with mental disorders are particularly ineffectively served in these general or medical/surgical hospitals (Kunen, Niederhauser, Smith, Morris, & Marx, 2005). Even when these patients are identified and transferred to the specialty unit within these hospitals, they are often treated very briefly and largely with nursing observation and medication only. After a few days, these patients are often released back into the community with little linkage with comprehensive outpatient psychotherapy and follow-up is often medication only. This approach to treatment can result in under treatment, re-hospitalization, medication non-compliance, medication side effects, and increased long-term costs.

Clearly, there needs to be reform of staffing pattern requirements in community hospital emergency services (ER, and on the general hospital staff) to include psychologists and psychiatrists in sufficient numbers to cover the ER and consultation and follow-up specialty treatment on medical/surgical wards and post hospitalization. Without such reform, ER and community hospital inefficiency and cost increases are likely to continue (Kunen, Niederhauser, Smith, Morris, & Marx, 2005).

In the area of growing medication costs and expenditures it is believed that the drivers of pharmaceutical inflation include; maneuvering by manufactures to switch patients to newer and higher cost drugs, increased utilization and contrived demand for drugs, and manufacturer price increases. The agency points out that the average retail prescription price has increased two to three times as fast as general inflation in recent years (Kreling, & Hanley, 2001), and that the cost of newer drugs often show no appreciable improved outcomes or effects (Hansen, 2005). Thus, a plan to address price and cost increases in health care without addressing the pharmaceutical industry and drug costs would be ill conceived.

The Government agency notes that prescription utilization is increasing rapidly with per capita use increasing by more than two prescriptions per year in the past ten years. The annual rate of increase for prescription drug expenses in the reporting period 1995-2000 was a whopping 15% (National Center for Health Statistics, 2004). This was a higher annual rate increase than any other type of health expenditure. In the period 2001-2002 the average annual prescription drug expenditures increased 15-16%. The portion of prescription drugs paid for by private health insurance rose 24% in the period from 1990-2002. Thus, a plan to address price and cost increases in health care without addressing the pharmaceutical industry and drug costs would be ill conceived, and would indicate a lack of knowledge about what is driving health care inflation or a lack of resolve to address core inflation drivers.

Increasingly, mental patients (and especially children) are being given drugs only instead of following "best practice guidelines" by providing psychotherapy and medication interventions (Norton, 2005). Further, some economists indicate that the

absurdly high prices for prescription drugs place these medications out of reach for millions of Americans, and for hundreds of millions of people in developing countries. They conclude that patent protection that undermines the competition in the free market is to blame for increasing drug costs (Baker, 2005 p., 30). Economists with this perspective indicate that there is plenty of evidence that 17-year patent protection for drug companies has a negative effect on consumers and the health care system. They hold that there are better ways to protect appropriate profits and to encourage research and development. This perspective points out that research supported by Universities, Government grants, and philanthropic organizations would continue development, build long-term development infrastructure, put the results of such research into the public sector, and ultimately bring down drug prices. From this position, experts indicate that the 17-year patent should be shortened for essential items such as medical pharmaceutical products in the interest of a balance between the need for appropriate levels of drug company profits, and incentives and competition in the drug markets.

Any health care reform that does not address patents in the pharmaceutical industry misses the mark for dealing with core cost and inflationary drivers. Efficiency focused health care reform would be focused on the real core problems in the health care system (hospital costs, drug costs, and specific cost drivers related to specific diagnoses and related procedures rather than window dressing. Blanket cuts of health care services to the poor is one example of such window dressing. Certainly, specific cuts of services to the poor would be well reasoned with economic and efficiency data as the basis for the decision, and they would be imbedded in a comprehensive health care reform plan that would include hospital cost, drug price, and specific identified cost driver components.

However, significant and general health care cuts to services for the poor without redress to core inflation and expenditure drivers misses the mark all together.

The Problem of the Changing Population Demographics

One of the problems for health care resource planners is the fact that this country's population is changing. Persons 65 years of age and older consume the highest per capita doses of prescription drugs. Increasing drug costs are especially hard on the elderly and the poor. In the year 2000, 88% of persons age 65 and older take a prescribed drug. The aging of the baby boomers is soon to create the largest group of retired and aging patients in the history of the US healthcare system. Taking care of the expanding sub group represented by the elderly will become one of the challenges for the health care delivery system.

The life expectancy of a baby born in the US was 57 years in 1929. However, the growing total expenditures for health care in the US and the use of that investment to improve the product delivered and to advance technology has led to dramatic results. Due to the effectiveness of the US healthcare system, life expectancy grew to 75 by 1990 (Miller, 2004, p741). Current life expectancy for men and women is nearing 80 years.

When economists want to estimate the return on health care expenditures they compute a figure that factors in the value of additional years that better health care may add life expectancy (related to additional contributions to GDP, tax revenue, investment, job promotion, consumption, etc.). One such calculation indicates that a reasonable estimate of return on investment is about $12,500 per year of additional life expectancy per person (Miller, 2004, p. 740). In other words, expenditures on health care work as an economic investment! Most economists agree that we spend a considerable amount of

our GDP on health care. However, the value of those expenditures on the long time-horizon is very positive and a boost to the economy.

The picture is complicated. While viewing health care as an investment and a boost for the GDP, it is clear that the growing sector of the US population that we call elderly consumes the greatest volume of health care resources. It is a two edged sword. As an industry, those in health care have succeeded in keeping our customers healthy, expanded their years of productivity, and expanded their well-being and life expectancy. That is the up side, like all things in economics there is no free lunch-there is also a down side. In doing so we have added to the costs of health care by becoming efficient at keeping the pubic healthy and alive and have increased the numbers who are becoming elderly. However, no good deed goes unpunished! The industry is being criticized by some for a consequence of this success-increased total health care spending and increased public demand for services due to their improving value and effectiveness!

Another problem for the health care delivery system also relates to improved technology, treatment efficiency, and to having solved many specific health-care riddles. The industry has found ways to keep the most seriously ill patients alive through complex and often expensive interventions. The top 5% of health care users consume over 50% of all health care expenditures. As one might expect, the elderly consume more than four times more per capita health care than the rest of the population. It is therefore clear that the chronically ill and elderly consume most of the nation's health care resources, and with the sub-sector that we call elderly is growing. Consequently, there will not be a reduction in health care expenditures regardless of the strategy developed by the industry and the Government.

Even if strict rationing is used, black market services and huge amounts of uncompensated care (charity) resulting in cost offsets paid by the insured will emerge. The elderly hold a great deal of wealth resources, are organized and vote, and are hence powerful political stakeholders. Their children often revere them. It is not likely that rationing of services to the elderly will be a health care reform plan that will gain much traction with the public. Such an approach would be counterbalanced by strong political pressure to limit rationing to a small number of situations and disorders where a rational and compelling case has been made and humane implementation safeguards are in place. Such infrequent, and highly supervised rationing approaches are not likely to have a major impact on over all levels of health care expenditures.

Further, illegal immigrants, outsourcing, and erosion of the US industrial base are putting downward pressure on wages making it difficult for families to afford health care coverage. A secondary effect of these labor input maneuvers is to increase the competition in some industries and employers compensate by cutting benefits and one major cut is often employee health care coverage. Thus, increasingly employers are deciding not to offer health care coverage for their employees. These economic trends have added millions to the costs of Medicaid and uncompensated care for health care facilities and providers. As the middle class looses economic stability and wealth they become less able to fund their own health care or access arrangements with employers who provide coverage for them. This evolution of the US workforce is beginning to move more individuals and families into the range of applicants for Medicaid and other Government health care systems. The middle class is drifting toward poverty. The strategy of preventing the Medicaid and Government health care systems from growing,

and cutting access to these programs at a time when more will need them will likely cause more economic and political tension rather than creating real solutions.

At the beginning of his second term, the President of the United States, and his council of economic advisors acknowledged to Congress that:

> While flexible institutions may speed the economic integration of the foreign-born, the distribution of the gains from immigration can be uneven. Less-skilled U.S. workers who compete most closely with low-skilled immigrants have experienced downward pressure on their earnings as a result of immigration, although most research suggests these effects are modest. Also, communities contending with a large influx of low-skilled immigrants may experience an increased tax burden as immigrant families utilize publicly provided goods such as education and health care. (Economic Report of the President, 2005, p. 91)

It is clear from the top economists in the country and the White House that more individuals and families will be unable to afford health care coverage (downward wage pressure, and out of control immigration), even if they are working. Further, it is clear that those analyzing the data are cognizant of the fact that the cost burden of these cost drivers will be born by states, local communities, and health care providers who must shift the costs to Medicaid, insurers (and ultimately employers providing insurance), managed care companies, and local tax bases. Certainly, one way to adjust to the rising Medicaid costs that these factors will cause, and that the White House acknowledges, is to cut services to the poor and stop the budgetary bleeding which the open immigration and outsourcing policies cause. However, that is a short-term fix with long-term costs. If workers incomes are eroding, employers are under competitive pressure not to use US workers or to cut their health care coverage, and communities will experience increased tax burden to adapt to these factors, then this is the worst time for the federal government and states to cut Medicaid services to the poor.

A case can be made that Government policies are creating greater public service health care demand, and cutting public health services during increasing demand no sense. Such a policy pretends that a short-term budget savings will occur in a vacuum. It forgets that the poor

and eroding and increasingly uncovered middle class will not evaporate or that that their health care needs will simply go away. The poor and downward drifting middle class will not have the resources to cover their health care needs and the government will be very transparent as they appropriate resources to deal with them or ignore them! In fact, the government is building themselves into a corner in which they will be forced to add to the growing health care expenditures trend or "become the enemy/problem" for the middle class and the poor. Not an enviable context in which to run for political office or attempt to maintain a political office.

I predicted this in a chapter in a book and in a paper in 1996 and 1994 (Morris, 1996; Morris, 1994). The difference was that the ill-conceived and non-core problem focused method chosen by the government in the 80s and 90s was the managed care approach rather than ration resources to the poor. During the mid 1990s I pointed out that the Government, that was setting up Managed Care as the solution to health care cost increases and ignoring the core components of "spiraling hospital and drug costs" (the true cost increase drivers), would fail. It has, and there is mounting frustration and legal action against the invisible rationing integral to it. I predicted that the Government would create managed care, it would fail since it did not address any of the real inflation and expenditures drivers discussed above, and later would rush in saying "we must act to save you once again"! I further posited that this "false savior" approach would not conceal the government's unwillingness to address the specific and difficult core inflation and expenditure drivers.

It was clear that such Government action would be faced with needing to address the two core cost increase drivers ignored by an excessively global and ill-conceived approach in the past. At that time, the cry from legislatures was that "doctor inefficiency, and waste, fraud, and abuse" were the real problem. This was absurd! The data simply did not support that these doctor variables contributed large enough effect to drive the inflation or increasing expenditures trend! It was simply a sexy red herring that could be used to mobilize public resentment of highly compensated doctors and the feeling that the Government was doing something meaningful in a

leadership role to address the health care inflation problem. The numbers said it was hospital and drug costs among other things that were the core issues, but the Government insisted on something a little more politically doable and scape goated doctors. The Government moved to pass laws creating and subsidizing managed care approaches in the early and mid-1980s (Morris, 1996). Managed care approaches are a government invention, not a private sector invention!

Thus, there are pressures that will change the make-up of America. Wage declines and more decent into poverty are not only likely, but these trends are recognized by the top economic advisors and the White House. Managed care approaches did not curtail Medicaid expenditure increases or inflation as promised and did not put the savings back into increased services as envisioned (Morris, 1996). Plans to cut Medicaid and other health care programs for the poor and infirm make the same mistake of avoiding careful definition of the problem and inflation drivers and focuses on creating a politically doable rather than potentially effective approach. According to some social scientists and economists this couldn't come at a worse time when there is increasing demand, increasing need, and increasing numbers of indigent and uncovered patients for which to care (Rank, 2005).

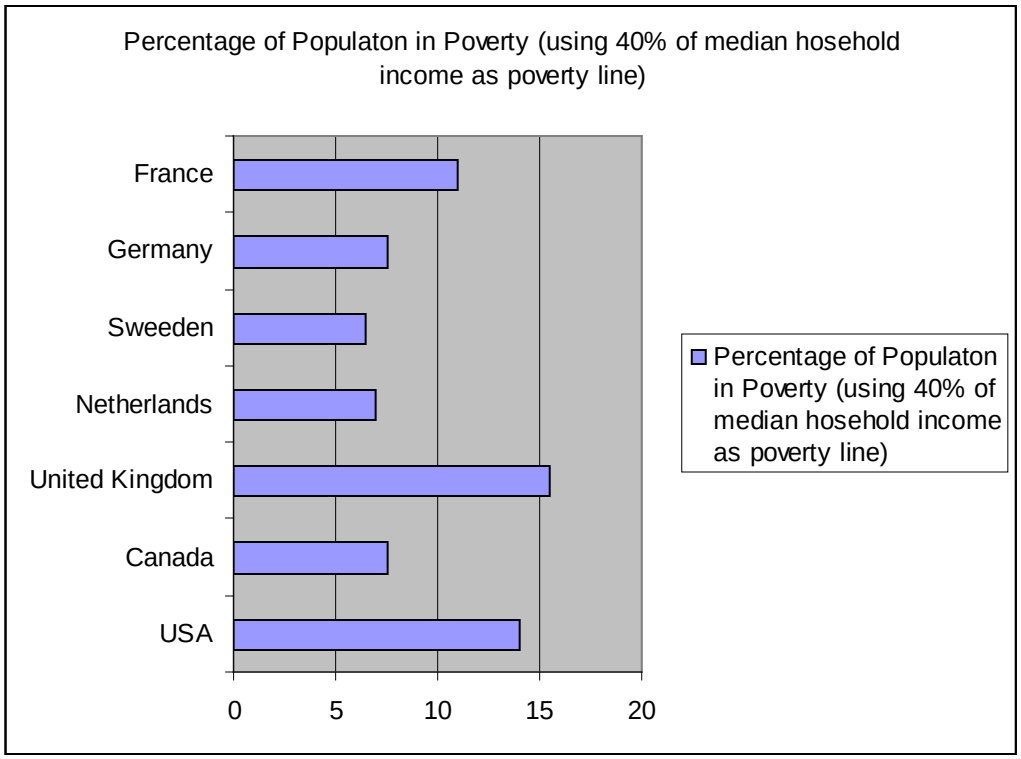
The unanticipated consequences of the draconian Medicaid cut plan (net losses rather than budgetary gains) are not being adequately debated. A substantive plan to handle these offsets and transfers and specifically addressing core cost drivers must be developed before once more acting blindly to cut programs under the hope of cutting total expenditures and inflation. Without a comprehensive understanding of the health care problem and redress of the core cost and inflation drivers instead of one more set of scapegoats will result in one more cycle of health care reform failure. A comprehensive plan (addressing core cost and inflation drivers and adjusting for the investment effect related to health care expenditures) would also including new program expenditures related to cost shifting, expansion of existing programs outside the Medicaid program, and other economic stimulants targeting the poor and those sliding downward in the middle class and loosing their health care coverage. Where the poor dropped from the

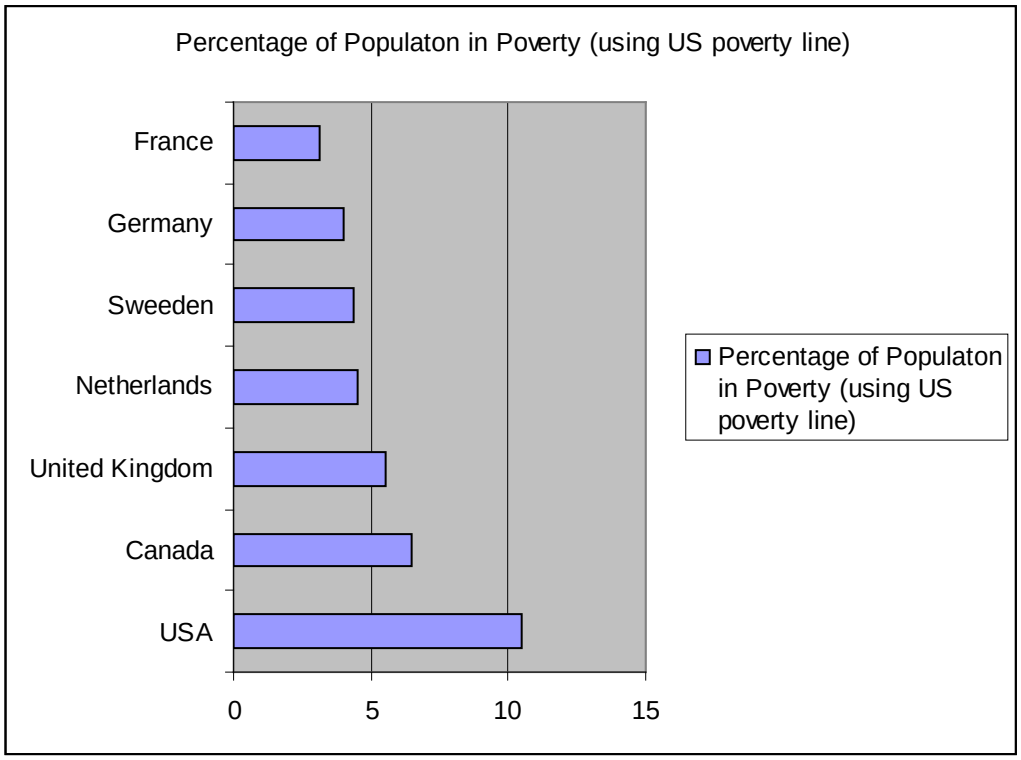
Medicaid rolls will be treated and estimates of the costs of treatment in the new system would be specified and easily compared to current costs under the Medicaid program. The extent of use of techniques like rationing, exclusion of specific services and diagnostic categories or conditions, and planned and unplanned barriers to access and their effects would be specified. Program costs related to increased social unrest, enforcement and regulation, workforce effect, and implementation costs would be realistically estimated and built in to the plan and the cost/benefit analysis. The plan would be comprehensive, complex, and would require much education and consensus building prior to implementation. Such a plan is a five or ten year project.

Poverty and Income Inequity

If we accept that the growth of efficiency and attractiveness of the health care products and results offered are driving growing demand for health care services, and that failure to curtail hospital and drug costs and related profits, and changing demographics and workforce supports are core elements of any plan to realistically address health care inflation and growing expenditures. However, another driver of future health care expenditure expansion will be poverty. As children born in the late 1950s and early 1960s entered adulthood the economic base of America changed. Many believe that one of the significant factors which drive healthcare spending increases is the growth of poverty.

The industrial base has eroded and our economy has become a service economy (McConnell & Brue, 2005, p. 75). Poverty has gradually increased since 1970 to the point that over 30 million people in the United States of America live in poverty (Miller, 2004, p. 731). Although the US is the wealthiest and most powerful country in the world, by contrast we have far and away the most poverty of any Western industrialized nation (Rank, 2005, p. 5). The chart below depicts this situation graphically (Miller 2004, p. 733):


Percentage of Populaton in Poverty (using 40% of median hosehold income as poverty line)
France
Germany
Sweeden
Netherlands
United Kingdom
Canada
USA
0
5
10
15
20
Percentage of Populaton in Poverty (using 40% of median hosehold income as poverty line)


Percentage of Populaton in Poverty (using US poverty line)
France
Germany
Sweeden
Netherlands
United Kingdom
Canada
USA
0
5
10
15
Percentage of Populaton in Poverty (using US poverty line)

Obviously, these graphics show that poverty is prevalent in the US, and that we are a leader in creating poverty regardless of the index used to classify the poor and among comparable industrialized countries.

The Gini ratio (a measure of trends in income distribution based on the Lorenz curve) indicates an increase in the inequality of wealth in America with an upward trend indicating that indeed the rich are getting richer and the poor are getting poorer (Parkin, 2005, p. 419-420). As people age, incomes decline, and more of the elderly slip over the line into poverty regardless of the definition or where we draw the line.

Roughly one fifth of our population is either living in poverty or on the verge of descending into poverty. By the early 21st century the modal income in the US was received by 7% of households, and their income was between $10,000-$15,000 (Parkin, 2005, p. 416). The U.S. had a higher rate of poverty (10-13%, depending on the measure used) than most European countries (Miller, 2004, p. 733). Of the 18 most developed countries in the world, the US has the highest percentage of children in poverty (22.3%), the second highest number of elderly in poverty (20.7%), and the third highest overall poverty (13.6%) by one recognized measure, and the highest overall poverty (17.8%) by another (Rank, 2005, p. 34). Imagine the affect on society and the economic system when 1 of every 5 elderly persons and child lives in poverty!

Of the 12 major industrialized countries, only the poor in two other countries (Australia and the United Kingdom) have less purchasing power than the poor in the US (Rank, 2005, p.5). When the marker of the number of persons who fall below 50% of a country's median income is used as the poverty line is used the US has far and away the highest overall poverty rate of the 18 top industrialized nations.

Some portions of our population are hardest hit by poverty. Poverty remains a much greater problem for Hispanics and African-Americans than for European-Americans (Bade & Parkin, 2004, p. 466).

Wealth has become increasingly distributed to the point that 50.2% of the U.S. annual income for households is controlled by the top 20% of the population, and the top 40% of the U.S. population controls 73.2% of all income (McConnell & Brue, 2005, p. 75). Eighty seven percent of shares of domestic output are controlled by corporations (even though they make up only 20% of the firms in this country), yet corporations only pay 8% of U.S. taxes collected (McConnell & Brue, 2005, p. 86).

Working people, 46% through personal income tax, and 38% through payroll taxes (McConnell & Brue, 2005, p. 86), pay most of the costs of State and Federal Government social service programs. The middle class and poor are in a growing squeeze with increasing US reconsolidation of wealth at the top, increased burden to fund Government on the backs of the poor and working class, increased erosion of the industrial base, and jobs that don't require significant investment in advanced education.

Thus, poverty is increasing, and dependency on Government services is also increasing for the poor and aging. The poor are considerably more likely to be in poor health and less likely than the non-poor to have used many types of health care. They are vulnerable and need health care services that can only be supplied by the Government. In the most recent reporting period (2002) the percentage of persons reporting their health status was problematic (as only fair or poor) was more than three times higher for persons living below the poverty level as for those with family income more than twice the poverty level (National Center for Health Statistics, 2004, p 26). Poor persons were four

times as likely as others to report serious psychological distress and when poor and minority persons with mental disorder go to emergency rooms for treatment (the place they must often go) their mental disorders are poorly identified and they are rarely linked with specialists qualified to treat them (Kunen, Niederhauser, Smith, Morris, & Marx, 2005).

Clearly, the poor are in a more vulnerable position in the US than ever before. In the last five years hunger in American households has risen by 43% (Brandeis University, 2005). California, Texas, Arkansas, Missouri, North Carolina, New Mexico, Oklahoma, and South Carolina all have hunger rates that are significantly higher than the national average. A recent report analyzing how the children of the poor and disabled would do under the National Governors Association cost-sharing proposals before Congress (raising Medicaid co-pays and cost sharing for people already economically destitute) indicates that there would be serious negative effects (PICO National Network, 2005).

This report indicates that raising co-pays and spend downs under this plan could place unrealistic barriers to access to services for the poor ranging from 5% to 7.5% of their already inadequate family income. A family of three at 101% of poverty could pay up to $813 annually under the plan before they could access health care, medications, early assessment and treatment of illness (a way of preventing long-term catastrophic costs and cost increases). This approach prevents health care for the poor who do not have discretionary income to invest. That is all of the poor, by definition. It functionally removes them from the Government rolls by the requiring unrealistic family health care investments. Doing so functionally removes them from the Medicaid rolls by requiring impossible financial investments before they qualify. This will reduce the Medicaid rolls

and total expenditures, but the poor and their costs do not evaporate. These costs are just transferred to other programs and parts of the economic system.

Estimates indicate that such an approach, and aforementioned barriers to access, would increase the number of uninsured children (due to inability to meet co-pays and spend downs functionally disqualifying them for coverage) by between 6% to 18%. The medical cost offsets, long-term costs due to late diagnosis and late stage treatment of illness, and to lost workforce entry and productivity are likely to be greater than the $1.2 billion in anticipated budgetary savings over five years. The ultimate costs to counties and municipalities, juvenile justice and court programs, county and city hospitals, etc. would potentially be astronomical and has yet to be estimated by qualified economists even though the plan is already in the beginning stage of implementation.

Summary and Conclusions

Obviously, there are a growing number of US citizens who will not be able to care for the needs of members of their families. The problems of the poor and the disabled are not easily simplified. Poverty and disability are not simply failures of character, genetics, or motivation, but are rather a complex interplay between contextual factors (training, jobs, mentoring, social support, economic, and leadership resources available in the family, neighborhood, geographical area, and cultural context), family stability and traditions and supports, mental and physical status, and genetic predispositions and aptitudes of the individual. It is clear that health care costs increase in impoverished populations, and that being uneducated, in a large family, being of certain races, a member of certain types of households, and being in the oldest and youngest households in the country increase your chances of slipping into poverty or near poverty states

(Parkin, 2005, p. 420). Once impoverished all have a stake in provide resources and methods for ascendancy out of the condition. It is clear that the long-term trends are indicating that we will have more poor, more elderly, more racial minorities and under educated, and more economically disadvantaged household and family configurations in the future.

Therefore, population characteristics indicate that greater expenditures on health care and services for the poor will be the necessity if these trends reversed. Reducing poverty and adequate planning and adaptation to the changing population are the ways to increase the efficiency of the Medicaid health care system. Simply cutting Medicaid and services to the poor misses the larger and more complex point of these data trends. Such an approach will begat more costs and will shift costs to future generations without addressing root causes of health care inflation and total spending. It will repeat the round of scape goating and failure to address core cost and inflation drivers apparent in the health care system.

Further, current efforts to curtail health care inflation and total expenditures have not significantly addressed the core cost drivers. Hospital inflation and medication inflation have been given a pass in health care cost containment planning. How could this be? Further, the system of exempting hospitals from taxes and giving them massive philanthropic and Government grant and tax support has not made them efficient and a driver of competition and downward cost pressure in the health care industry. One would think that an effort to seriously address health care inflation would deal with the broken non-profit hospital system.

It is also clear that health care expenditures function as an investment as well as a cost, and therefore we cannot reduce these investments without corollary economic costs. At worst, a sophisticated economic analysis of Medicaid and like investments and plan for change must reduce cost estimates by the amount of economic stimulus and gain before it makes sense to implement the approach. Present political rhetoric fails to integrate a cost/benefit analysis of appropriate design. Change in health care delivery systems is complex and can not be based on political platforms, class resentments, or benefit to a faction within the economic system without regard to affects on the whole system. We are not yet ready to define constructive health care inflation and expenditures curtailment agenda's and initiatives for addressing and defining the health care problem in America. Without a more substantive and complex vision of the core problems and the positive effects of industry investment, and a substantive discussion of the complexities of change implementation, we are likely to blindly enter into feel good agendas with heavy economic consequences. We must stop chasing rabbits down wholes if we are to avoid cyclically joining Alice at the mad hatter's tea party. It is small wonder that the public watches these unsuccessful health care reform juggernauts and ends up observing-"curiouser and curiouser"!

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