

## The United States Healthcare Crisis: Using Our Bold Voices to Effect Change

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**B**aseball season is upon us. This may seem an incongruous beginning for an editorial on critical care issues. It is even more incongruous given that one of us (CBB) grew up in a world of cricket where games were measured in days not hours and both teams frequently broke off competitive play to drink a leisurely cup of tea. The other one of us (KD) was subjected to parenting that included years of earnest but uncoordinated children playing Little League, where games were measured in hours that seemed like days.

Nonetheless, our collective editorial eye caught a recent story in the newspaper about ex-Orioles star Brady Anderson.<sup>1</sup> Mr Anderson is a 15-year major league veteran who last played in the minors in 1987. He was released from the Cleveland Indians last May after a 2-year batting slump and chose to play for a San Diego Padres affiliate in the AAA league rather than retire from the sport. At age 39, he joined a team of players who were, on average, almost half his age.

How is Mr Anderson different than the other players on his farm team? According to his manager, “He teaches [players] to swing at pitches you want to swing at, not at what the pitcher wants you to swing at. Brady never allows pitchers to control an at-bat. That’s the difference. If these kids had that down, they’d all be in the big leagues.”<sup>1</sup>

The gift of this veteran athlete is his sense of control over the game. He doesn’t just respond to pitches; he manages the pitcher-hitter interaction. According to his new manager, he demonstrates an attitude of personal control over the game that is based on his belief that he is in charge at home plate. We don’t know if Mr Anderson will be successful in his attempt to get back to the majors, but we think that he can teach us something about our healthcare system.

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### The Healthcare System

There are many amazing and marvelous aspects of our system. First, healthcare professionals, particularly nurses and physicians, have never been better educated or available in higher numbers to care for the public. For example, despite the current nursing shortage, the number of nurses working in the profession has doubled over the past 40 years from fewer than 1 million nurses to approximately 2.2 million. Second, the care given to patients hospitalized in critical care is guided by the results of research and the accumulated wisdom of best practices in a way that did not exist until we discovered that evidence-based practice makes a difference in patient outcomes. Third, we have begun to understand that our role in caring for patients at the end of life is just as important as saving them from an acute illness. As this realization is codified in critical care, our care will become ever more humane.

In partnership with the medical and pharmaceutical industries, we have developed an amazing armamentarium to diagnose and treat illness. These technologies have increased life expectancy for both men and women and have changed the survival statistics for many conditions. We can scan anything and everything: knees, brains, and hibernating myocardium. We can defibrillate a patient who is thousands of miles away from us. We have developed amazing silver bullets to treat disease. Unfortunately, we are delivering these miracle bullets in the weapons-equivalent of a wheelbarrow (ie, our dysfunctional healthcare delivery system).

### A Broken System

Our healthcare system is faltering. It is complex and inefficient at the same time. According to Marcia Angell, former editor of the *New England Journal of Medicine*, “If we had set out to design the worst system we could imagine, we couldn’t have imagined one as bad as we have.”<sup>2</sup>

Most readers of this journal have healthcare benefits and therefore are protected from the anxiety felt

by almost 15% of the American population who are uninsured. But every day each of us deals with the consequences of confusing regulations, denied authorizations, and diminishing reimbursements that result in staff layoffs and higher patient-nurse ratios. Each of us cares for patients who face an uncertain future about how they will pay for the healthcare they need. Most of us are a pink slip away from being uninsured. Even if insured, none of us are exempt from an administrative decision to increase copayments, decrease coverage, or increase employee contributions to insurance premiums in order to maintain an institutional bottom line.

### **How Did We Get Here?**

Employee-based health insurance traces its roots to the early 1940s, when it served as a strategy to avoid wage and price controls, and it is now ingrained in the culture of the country and the workplace. We expect health insurance as part of a good employee benefits package. Unfortunately, the inadequacies of this model as a system of care are reflected in the national statistics on medical spending, the double-digit increases in premiums that even those who are insured have experienced during the past 4 years, and the increasing numbers of Americans who are uninsured.

In 1960, the United States devoted 5.2% of its gross domestic product (GDP), which is a measure of a country's production of goods and services, to healthcare. That percentage is now more than 14% and is twice as much as the median of the 29 members of the Organisation for Economic Cooperation and Development. Japan, Australia, and Canada spent 7.3%, 8.3%, and 9.3%, respectively, of their GDP on healthcare in the last year that statistics were available.<sup>3</sup> But talk of GDP is too abstract. What did the average American spend on healthcare? In 1997, it was \$4,090 compared with the average German who spent \$2,339. In Japan, Australia, and Canada, the range was between \$1,741 and \$2,095.<sup>3</sup> Do Americans get double the value in healthcare of these other countries? It is a question to ponder long and hard. . . .

Each decade, the steady rise of healthcare costs has been greeted by a new attempt on the part of our government to set controls. In the 1970s, the Nixon administration instituted cost controls. In the 1980s, Medicare adopted prospective payments and diagnostic-related groupings as the basis for healthcare financing. The 1990s brought Clinton's failed proposal and the promotion of health maintenance organizations as the answer to rising costs. Now there is pressure by employers to increase copayments and require higher deductibles, shifting the rising cost of care to the indi-

vidual. This grand strategy of placing the financial burden on the individual who seeks healthcare is supposed to reduce costs. We are not optimistic.

Today, 41 million Americans are uninsured, two thirds of whom are mothers and children.<sup>4</sup> When looking at the global rankings of infant mortality rates of children under the age of 5, we find that our peers are Malaysia and Croatia. We are 54th when it comes to access to healthcare for women and children.<sup>3</sup> Alarming disparities exist in people's access to healthcare, the treatments they receive, and the morbidity and mortality they suffer when they are an under-represented minority.<sup>5</sup> We need bold voices that will speak out about everyone's need for healthcare, particularly those who live in poverty and are from under-represented minorities.

Who are the uninsured? They are not who you think; they are not necessarily unemployed. In fact, 80% of households without health insurance have a family member who works full- or part-time, often in a small business that cannot afford to offer health insurance as an employee benefit. One third of the households make more than \$50 000 dollars,<sup>6</sup> but a catastrophic illness can wipe out financial stability and even lead to homelessness.

### **Universal Healthcare**

Our country has universal healthcare—it is called the emergency department. Emergency departments cannot turn patients away, but is this a good use of the intensive technology and highly skilled staff that comprise the emergency department milieu? Underscoring the point that emergency departments are used as a safety net in this country<sup>7,8</sup> is the fact that only 37% of patients who visit emergency rooms are there for injuries, and of these patients, only 10% receive trauma care services. The current situation of overcrowded emergency departments, increased frustration of staff, reluctance of physicians to serve on on-call panels (because of a risk of being called for uninsured patients), and ambulance diversions is untenable.

Other sources of care come from the network of free or subsidized clinics across the nation, many of them staffed by volunteer nurses and physicians who recognize society's obligation to care for the poor. Again, is this the way the richest nation in the world provides healthcare for its people?

### **Rising Above With Our Bold Voices**

During Connie Barden's recent presidency of AACN, we heard about the need for critical care nurses to use "bold voices" and speak out on issues of importance for patients and their families. This year,

Dorrie Fontaine has taken the phrase “rising above” to signify the need for critical care practitioners to play an active role in shaping the future without being mired in the “what is.” We believe that we all need a heavy dose of both messages if we’re going to make a difference in today’s healthcare system. What might a single nurse or physician do given a healthcare system that has lurched from one attempted solution to another, with increasing money spent, increasing numbers of uninsured, and decreasing provider satisfaction? Nurses and physicians must consider all of the issues individually, but act globally.

Watching breast cancer survivors and Mothers Against Drunk Driving (to name just 2 groups), we have learned the power of advocacy groups. In both cases, women who shared similar experiences and values banded together to change the system legislatively and culturally. They spoke with bold voices, and they rose above the status quo. They lobbied state legislators and Congress to increase research money for breast cancer and to change laws related to speeding and driving under the influence of alcohol. They took to the air-

waves in their attempt to change attitudes. In each case, they were powerful and effective forces for change.

We need a new healthcare system. Nurses and physicians can speak out to engage the public in this important dialogue. We can insist that healthcare be in every candidate’s platform and be a part of every political debate. We can remind our patients, our legislators, and our professional organizations that the status quo is unacceptable. We need reform so that people will receive the care they need soon enough to make a difference. We need to improve the quality of the care we give while stabilizing its costs.

The goal of changing our healthcare system may appear impossible—a Don Quixote sort of battle. But as nurses and physicians, we have the most extraordinary power to create change. We have credibility because we are on the front lines. We see the consequences every day of the inefficiencies and cruelties of the system. We can tell stories that put a face on the crisis and make it difficult for legislators to continue business as usual. We can communicate the tragedy of our healthcare system as no others can. We also care what happens to our patients and their families and take joy in caring for someone who is critically ill.

We can turn to baseball for a lesson in perseverance and joy in the game. When a journalist asked Mr Anderson what it was like to be playing in the AAA league with young men who were just starting their careers, he said, “The best part is I get to play. I don’t like watching others play. As long as I can run and throw, I’m going to keep playing until I can’t.”<sup>1</sup> Mr Anderson does not have total control over the game. If he did, he’d be hitting the baseball every time he is up at bat, but he loves the game and controls the moment when he is at bat. Most of us have far more control than we realize at the intersection of care. We need to “rise above” the sense of hopelessness that many (especially our patients) have adopted related to healthcare and ask ourselves what we can do to make a difference. Then we need to do it!

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