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Healthcare Change and the Uninsured
Part I: Hope, Value, Virtue
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Recently, a friend sent me the following note:

> "As part of the solution to fix our nation's healthcare issues, I'm struggling with one key component. That's the education and behavior changes required from our uninsured population. How can we stop obesity and diabetes for the morbidly obese Medicaid patient who doesn't know any better and/or is not incented in any current fashion? I see all that the industry is doing and for a majority of the commercially insured population, these initiatives will make a difference. But for the uninsured population, we will have to change human behavior. To me, it's going to take national recognition to the true causes of the issues such as obesity to the same level as what our country did for tobacco and smoking. Obesity is our country's tobacco issue of 15 years ago. I'd really like your insight on the topic."

As an overarching principle in answering this question, it needs to be said that the uninsured are not a homogenous cultural, social, economic, or ethnic group. The financial pressures of obtaining healthcare are greater for them but that is not because they are a unique group with common problems. In other words, the uninsured do not represent a "healthcare ghetto" with similar psycho-social and/or physiological characteristics. The uninsured are in most ways just like the rest of us.

But, the questions are as much philosophical as it is medical. By contract, SETMA takes care of 25% of the uninsured patients who come to one of our local emergency departments. Your heart will break when you see these people. A 23-year-old on dialysis that when the patient leaves the hospital, will board a bus to ride 14 hours to Oklahoma where the patient's Medicaid is valid. A 21-year-old who is in need of a heart transplant but who can't get it. I could go on and on. You and I awaken each day with the expectation, borne of hope, that something good is going to happen to us today. Many in our country and in this world have never experienced such a day. The greatest hope some have is that they will not be shot in a drive-by-shooting today.

The equation which is required in order to improve health is to affirm the proposition that "if I make a change, it will make a difference." If an individual, or even a group of individuals, has no experience with having changed lifestyles or having changed habits and then having seen that those changes made a difference in their lives, it will be very difficult to have them make changes and even more difficult to have them sustain those changes once they are made. The long-term value of the difference which results from change has to have a greater value to a person than the immediate gratification of the behavior which needs to be changed in order to improve long-term health outcomes. These are not simple problems because they are often more emotional than cognitive.

In 2008, the Institute for Healthcare Improvement (IHI) defined the Triple Aim of healthcare change to be "improved care," "improved health" and "decreased cost." To inform our transformation of healthcare, SETMA has restated these aims as: "improved processes," "improved outcomes," and "sustainability." The scope of the Triple Aim was actually defined by Senator Hubert Humphrey in 1977; he said: "The moral test of government is how it treats those who are **in the dawn of life**, the children; those who are in the **twilight of life**, the aged; and those in the **shadows of life**, the sick, the needy and the handicapped." (November 4, 1977, Senator Humphrey, Inscribed on the entrance of the Hubert Humphrey building, HHS Headquarters), quoted by Donald Berwick in his speech entitled, "*The Moral Test*" Keynote Presentation, December 7, 2011 IHI 23rd Annual National Forum on Quality Improvement in Health Care).

Resources – May be more personal involvement than public payments

Resources are needed to create hope, but money alone will not solve the problem. To improve the care, the health and the cost of the care of those who have long been neglected by our healthcare system, we must instill a sense of personal worth in all individuals. Personal worth was at the foundation of the reaction to President Theodore Roosevelt, who in 1901, invited African-American educator, Booker T. Washington, who had become close to the president, to dine with his family at the White House. Several other presidents had invited African-Americans to meetings at the White House, but never to a meal. And in 1901, segregation was law. News of the dinner between a former slave and the president of the United States became a national sensation. The subject of inflammatory articles and cartoons, it shifted the national conversation around race at the time.

I wonder if the solution to your question is African American families inviting Caucasian families to dinner in their home – a very intimate setting – or illegal immigrants inviting opponents of immigration reform to dinner, and…. This would give a new definition to the movie entitled, "Guess Who's Coming to Dinner?" This would not solve our healthcare problems but as each family invests value in the person of those who are "different from them," it could be a foundation from which others could value themselves and consequently for them to make wise decisions because they are worth the act of wisdom in health matters. I have just asked my wife if when we return from several weeks away, if we can invite an African-American family to dinner in our home – not a friend's family but at least an acquaintance if not a stranger. She, of course, said, "Yes."

For health care providers, who are dealing daily with people with chronic, debilitating and often devastating conditions, hope – defined as "to desire with expectation of obtainment" – is often missing in patients, particularly uninsured patients. Without hope, people will not make the changes necessary to retain or regain their health. The question is then, "How does a healthcare provider help someone who has no hope; who has given up, or who is not willing to help himself?" Is it possible to create hope in others? Is it possible to "hope" for others? What is the foundation of hope? Why do some have it, in spite of their circumstances and others do not? How do you help someone who either consciously or unconsciously doesn't make the connection that their modifying behavior can make a difference in their future?

Value

To answer these and other questions, we have to understand the foundation of hope. Where does hope come from? How is hope created? First, hope is founded upon the intrinsic value of the individual. "Intrinsic" means "belonging to the essential nature or constitution of a thing." In other words, a person's value is not a result of what they have, what they do, or who they are; the value of a person is as a result of their being a "person." This is a foundational principle of western civilization and particularly of the value system of the United States of America. It is not the state which is of ultimate value; it is the individual and it is not the individual as a "concept," but as a person. There is no doubt that some are honored more than others because of what they have and/or of what they have accomplished, but objectively in our culture, we do not value the life of one above another.

How then do healthcare providers instill in others the sense of their value and of their worth? How does this practically operate every day? Perhaps no other group can so readily and directly communicate the value of life to others as can health care providers. And this is done first by the respect, dignity and compassion with which each person is treated in the clinical setting, whether hospital, clinic, emergency room, nursing home or other location. Simple things like shaking the hand of a person while looking them in the eye and greeting them by name are the beginning of this exercise. In the healthcare setting, each individual, whether a bank president, or not, can be addressed by their title -- Mr. or Mrs. or Miss -- until and unless the relationship is such that addressing a person by their first name is appropriate.

It may be that the respect and dignity with which an individual is approached in the clinical setting instills a greater sense of the personal worth of an individual than even the excellence of the care they receive. This is not to suggest that inferior care is balanced by compassion, but it is a fact that excellent care given in a negative environment will not benefit the patient as much as that given in a caring, affirming relationship.

The value of life and the personal value of the individual are the root of our healthcare decisions. The choice to live rather than to die is the first choice based on that value. The choice to make healthy decisions about behavior, access of care, follow-up and follow through on treatment recommendations are all founded upon the value a person places on life and on their own life. Because these judgments of value are often not cognitive -- they are often not things we consciously think about -- a person may be unaware that they are making a decision about their personal, intrinsic value, but they are nonetheless.

Instilling Hope in Others

Beyond their personal interaction with patients in the clinical setting, how can healthcare providers contribute to the development of hope in a patient through the affirmation of personal value? An optimistic view is helpful. Optimism is not created by the ignoring of reality, but it is assuming the best while facing other possibilities. If a person has no value, it is possible to be fatalistic and assume the worse; if they are highly valued, optimism will be the intuitive default position.

Next, the healthcare provider builds a sense of the value of the individual when he/she addresses the future of the patient from a perspective of change. "Here is where you are today, but with the following actions, you can change that future," is not only an expression of optimism but it is a result of clinical competence to know what can and what should be done to make things better. Rather than quickly dismissing the patient -- and this is not a function of time spent with the patient but of total focus on the patient's future -- providing the patient with a plan of action for improvement of their health invests value in them.

Follow-up is one of the most important evidences of the value of the individual. When a person is given appropriate interval follow-up, it instills in them a sense that someone else cares, and even if life's experience have diminished their own caring about themselves, that caring can be regenerated through others caring about them. A part of follow-up is access. When the only access a person has to a healthcare provider is when they are in the office, generating a bill, the relationship becomes commercial. When the patient has access to the counsel and attention of a healthcare provider, at an appropriate frequency, at other times, the patient begins to see that he/she has value to someone else and is more likely to begin having a sense of personal value. When a healthcare provider answers telephone calls in a timely fashion, he/she is instilling value, which is the foundation of hope, in the life of the patient. And, while this may not be a conscious transaction in the mind of the patient or provider, it is nevertheless the case.

Virtue

The second foundation of hope, which is actually the "engine," or the power source of hope, is virtue. Like hope, virtue has many definitions. *Webster's* gives one of them as "a capacity to act, potency." This is the sense in which virtue is an aspect of hope. We often, and appropriately, associate "virtue" with morality, but it means more than that. Without the capacity to act, hope has no means of impacting a person's life. However, a person who recognizes the value of their person -- regardless of their education, position, pocketbook or other external trait -- and who has virtue -- the ability to make decisions and act on them -- can change their future. Virtue provides the patient with the courage to make decisions which are uncomfortable but beneficial

Virtue allows a person to persist in a decision until the promised benefit is realized. The presence or absence of virtue is often the difference between success and failure. And, the absence of virtue does not mean that a person is evil or immoral in the sense in which we are using the term. The absence of virtue simply means that the person lacks the courage, the conviction, the consistency, or the capacity to change their behavior for the good of their person.

Here is a more difficult question, "Can a healthcare provider help a patient develop virtue?" Without doubt, it is hard, but it is possible. Virtue is more than the development of habits, but virtue's presence, or absence will result in habits being formed. The healthcare provider can help a patient develop positive habits with accountability and reinforcement of positive conduct. The healthcare provider can promote virtue in the life of the patient by celebrating success however small and by cheering the patient on to success.

In fact, the more successful the healthcare provider is in accomplishing the first element of hope -- instilling value in the life of a patient -- the more success he/she will have in promoting virtue.

The more a patient feels that the healthcare provider "cares" about them -- values their person, intrinsically -- the more "power" the provider will have to promote positive habits in the patient from which will spring virtue -- the capacity to act.