Family Physicians and Unintended Consequences

Joshua A. Smith, MD, MPH
University of Cincinnati/The Christ Hospital, Family Medicine/Psychiatry
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"The history of US Health Policy is one of unintended consequences"

Despite tremendous medical and technological breakthroughs, unparalleled funding, and good intentions, the United States lags behind other high-income countries in dozens of key health indicators, including life expectancy, avoidable deaths, infant and maternal mortality, obesity, chronic disease burden, and incarceration rate.[1,2] Health policy decisions were not made with the intention of suboptimal outcomes. So how did we end up here? In many ways, lack of foresight and limited expertise in health and healthcare have allowed the unintended byproducts and consequences of decisions to dominate in impact, despite the intentions of policymakers. And in the end, family physicians may be the intervention to change this.

Mental Illness: From Asylums to Incarceration

The recent history of mental health care serves as an emblematic example of action and reaction in US health policy. In the 1960s, two monumental pieces of legislation were put into place, which should have moved forward the mental healthcare system, but instead led to our modern day criminalization of mental illness. In 1963, in response to national outcry at the state of inpatient mental healthcare, President Kennedy signed the Community Mental Health Act (CMHA) to "create a network of community mental health centers where mentally ill people could live in the community while receiving care."[3] Two years later, President Johnson signed

into law Medicare and Medicaid. These laws were intended to care for those in need, however a specific clause in the 1965 legislation was written to prevent states from receiving double funding for individuals in psychiatric hospitals.

> *"Mentally disabled people living in the community [were] eligible for [Medicare and Medicaid] benefits, but those in psychiatric hospitals [were] excluded. By encouraging patients to be discharged, state legislators could shift the cost of care for mentally ill patients to the federal government."* [3]

State's could shoulder the financial burden of caring for those living with severe mental illness and keep them in state hospitals, or they could shift the costs to the federal government through Medicaid and discharge individuals to receive care in community mental health centers. For state legislators, the choice was easy.

There was a mass exodus out of state hospitals. However, due to limited federal support, the Community Mental Health Act was doomed from its inception. As detailed in a 2021 paper examining the CMHA, "Financial concerns [were] illustrated by a Bureau of Budget internal memo that read, 'The real question is who is going to finance operating costs once the federal subsidies are ended or indeed if they can be ended.'" [4] Initial funding for construction and staffing was provided, but further development and financing of community-based mental health care was left to the states. And as funding and support from the CMHA waned, "care often fell to families, friends, and associates. Those without homes often ended up on the streets, with many entering an institutional circuit of acute care hospitals, jails, prisons, and forensic facilities."[4] This inadvertent evasion of responsibility by the government effectively erased the mental health safety net. Subsequently, the rise of mass incarceration in the 1970s encouraged a criminalization of mental illness, resulting in the three largest providers of mental health care today in the United States being prisons - LA County, Cook County, and Rikers Island.[5]

Who Decided Employers Should Provide Insurance?

Mental health is not the only aspect of the health system driven by and debilitated by unintended consequences. In 1942, the Second World War drew away many of the country's eligible workers. Out of concerns that competition for workers would unsustainably raise wages and in turn plunge the US back into recession, President Roosevelt signed Executive Order 9250, leading to a wage freeze. In order to attract workers already in short supply, employers expanded benefits, including health insurance, "which resulted in a rapid increase in employer-sponsored insurance."[6,7] From then on, employer-sponsored health insurance became the dominant means for accessing care, and today nearly half of all Americans have coverage through their employer.[6–8] This has been shown to stifle economic development through reduced job mobility and entrepreneurship (known as "job lock"), [9–11] to exacerbate income inequality due to an effectively regressive tax policy,[12,13] and to widen health disparities between low- and high-income earners.[14,15]

"Efficient EMR": A Paradox

In 1992, the Institute of Medicine (IOM) endorsed the transition to a computer-based patient record, known now as the Electronic Medical Record or Electronic Health Record (EMR or EHR). The goal was to "provide total, cost-effective access to more complete, accurate patient care data… [to strengthen] the scientific basis of clinical practice [and to] contribute to the management and moderation of health care costs."[16] Now, given the trajectory of technology, it is clear that the IOM was correct in their prediction that implementation of computer-based records was inevitable. However, repeated studies have found that instead of bringing physicians closer to their patients, this development has separated them due to increased documentation burden and near constant workflow and systems changes.[17,18]

Abortion Restrictions Led to Labor Unit Closures

More recently, on June 24, 2022, the Supreme Court of the United States overturned a 50-year-old precedent in their decision in the case of Dobbs v. Jackson Women's Health Organization. This ruling removed federal protections to the right to pregnancy termination, explicitly writing, "The Constitution does not confer a right to abortion; Roe and Casey are overruled; and the authority to regulate abortion is returned to the people and their elected representatives."[19] This allowed "trigger bans" on pregnancy termination to take hold in states across the country, including Idaho, where the state's elected officials implemented a statute criminalizing medical providers who take part in pregnancy terminations.[20]

Just eight months after this statute took effect, the only labor and delivery ward in Sandpoint, Idaho, a town of 9000, 72 miles northeast of Spokane, Washington, closed. This decision forced patients in northern Idaho "to travel at least an additional hour for care… [hospital] officials said the law was a driving force in the closure."[21] While it is too soon to know how this shutdown will affect the town of Sandpoint, a 2018 study found that rural US counties that lose hospital-based obstetric services see "increases in out-of-hospital and preterm births and births in hospitals without obstetric units in the following year."[22] We will have to follow up in years to come to see how many more babies are born early, outside of hospitals, and how babies and mothers are affected by this unit closure.

Family Physicians: Today's Witnesses and Tomorrow's Remedy

The body of literature on unintended consequences in US Health Policy is immense, and one needs not look far to see any number of counterproductive policies, ineffective policies, or policies resulting in out-of-scope by-products.[23] However, as a resident training in Family Medicine, this literature serves more as a mirror, echoing back what I see each day in clinic.

Once you know where to look, how to trace back today's frustrations to yesterday's decisions, every day and every patient delivers a lesson in unintended consequences.

As a day in my outpatient clinic begins, I look at my colleagues. I see them at their computers- the same computers and electronic records that in 1992 were expected to bring us closer to our patients through more accurate data and streamlined clinical management. And as I scan the clinic, I see these brilliant and caring physicians overburdened by documentation, stretched thin by software updates, and inundated by alerts and checkboxes. There is no doubt that the EMR enhances chart review and eases data collection, but in exchange for the expected outcomes, many of us feel the need to choose between looking our patients in the eyes and looking at the computer to care for the electronic patients that exist only in the EMR.[24,25] We take work home and extend our clinic sessions because we want to be present with our patients, a task nearly impossible with the current EMRs. Was presence with patients considered when we transitioned to electronic records?

As I go through my day, I learn from patients, and as I hear their stories and navigate their concerns, my mind flashes back to choices of the past resulting in the chief complaint of today's visit. I will have a well-visit with a young person I have cared for since my first year in residency. She is living with severe depression and chronic suicidal ideation. We have been working for years to find the right outpatient mental health team to provide the most appropriate care for her. But because her father's job offers no health benefits, they rely on public insurance, and in turn we struggle to find the right team to care for her. Studies have shown that psychiatrists are less likely to care for children and adolescents on public insurance compared to those on private insurance and that wait times for a new patient appointment are longer for those on public insurance.[26,27] Who decided insurance should be tied to employment?

I'll see a patient for a chronic care visit who experienced repeated physical and emotional abuse in his childhood, mistreatment that led to traumatic brain injuries and PTSD. This subsequently resulted in substance misuse and self medicating, housing instability and

recurrent homelessness. Eventually this led to incarceration. Due to the criminalization of mental illness and homelessness, and subsequently due to limitations in housing and employment for those with a history of incarceration, he feels trapped by his past and struggles to see a way out. Data have shown that individuals who have been incarcerated once or more than once are 7 times and 13 times more likely, respectively, than the general population to experience homelessness.[28] Those who have been incarcerated at any point are 5 times more likely to be unemployed.[29] When did we accept that mental illness and homelessness were best dealt with through courts and convictions?

My schedule is full of individuals with health issues related to unintended consequences. Family physicians don't need to read about these unintended consequences - our patients teach us everyday. Some policy consequences are unforeseeable and perhaps unavoidable. Others can be identified before they take hold. Family physicians are the front line of our health system, meaning that we not only see downstream consequences, but we can see upstream if we choose to look. By keeping one eye on the structural determinants of health, the policy decisions that are being made in city councils, in state capitals, and in Washington D.C., we can be advocates for our patients and communities. We can insist that our expertise in health and healthcare is taken into consideration.

While the Community Mental Health Act was an excellent proposal, family physicians know what happens to underfunded initiatives - patients fall through the cracks. EMRs were the logical next step in health record management - but when our tools are built not for patient care, but for billing and compliance, our patients suffer. And anyone who has gone through medical training knows what happens when the office, hospital, or community becomes hostile to clinicians - clinicians leave, and patients are left behind.

These problems are too big for us to solve on our own, but together we can grant policymakers greater foresight. We can pool our voices and expertise in local and national organizations, like the AAFP and local and state chapters. Residency leaders and the ABFM

can implement more change-focused advocacy and public health curricula into graduate medical education. Family physicians can show up at city council meetings and write letters to elected representatives to make themselves available for questions and guidance. Family physicians can run for office themselves.

Learning to advocate is a lifelong process, and I've found that training in Family Medicine is a great place to start. Decisions are made by those who show up. For the sake of our patients and communities living in downstream consequences, both intended and unintended, family physicians need to show up.

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