Academic Commentary

Wolf Pack Theory: A Dilemma for Health Care Outcomes

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Abstract

It is incumbent upon health care leadership to provide vision and direction for equitable health care access and distribution of health care resources to all. However, to achieve this it is necessary to confront those factors that undermine health care equity, especially those that seemingly are culturally subconscious. One such factor is termed Wolf Pack Theory. Within the American context, this article explores Wolf Pack Theory as a selective bias within the insurance industry and public policy, negatively impacting equitable access to health care and health care outcomes. This article describes the phenomenon of Wolf Pack Theory in an attempt to promote and identify how powerful insurance and policy groups can provide positive leadership so as to close the disparity gap for health care access for at risk populations and achieving the best quality of life for all.

Keywords: health care bias, health disparities, social justice, population health

Introduction

One area of increasing cultural attention in the United States is the equitable availability of health care for all those who are in need. Over the course of many decades, strong discussions have taken place about this critical area, and many approaches to health care have developed. Such approaches always develop in relationship to innumerable academic, social and cultural factors that emerge, regardless whether such factors are positive or negative. One factor that is important in these developments is that of leadership theory. Leadership theories help to identify unique styles and best practices in achieving identified outcomes based on mission statements and goals in societies, cultures and nations.

Wolf Pack Theory is one such leadership approach or paradigm. It has applications to many professional disciplines and sociocultural contexts. Some of its applications can be undermining. This article focuses on Wolf Pack Theory's negative consequences upon group

behavior and the creation of equitable policy within the health care arena. This theory impacts and undermines interactional leadership and negatively affects the achievement of needed social justice goals for reducing disparities in both health care access and population outcomes. Wolf Pack Theory in the health care setting is defined as a group banding together on the basis of implicit bias or prejudice, thereby negatively affecting specific individuals or groups through any number of actions.

Wolf Pack Theory

Wolf Pack Theory is based on an innate survival instinct within the human person and human societies. Individuals band together in groups, either consciously or unconsciously, to achieve an identified outcome. It is well known that wolves live within packs for survival, and have a unique social order and structure called therian pack rankings (Tala, 2015), with the best hunting outcomes in small attack groups of three to five wolves (MacNulty, Tallian, Stahler, & Smith, 2014).

Wolves target animals that are vulnerable due to illness or weakness, the very young or elderly (International Wolf Center, 2019). There is cooperation within the pack in a successful kill that otherwise would not be achievable if done individually. The small hunting group results are termed "benefit of cooperation" and are followed by the "cost of cooperation," which involves sharing the victory kill with the pack (Viegas, 2014).

Successes are best achieved in small, cooperative groups with the leadership avoiding risk but allowed to participate in the victorious results. The cooperative group approach in the insurance industry and health care policy reflects this phenomenon.

The Insurance Wolf Pack

Insurance bias is defined as a favorable selection of enrollees by insurers resulting in disproportionate enrollment of certain groups of people. An insurance company's main focus is business. This focus on business is a powerful influence. The business of health insurance aims to spread risks from an insured individual to the larger group of the insured customers based on profitable business decisions and algorithms with the goal of a company net profit. Health Maintenance Organizations (HMO) achieve cost savings primarily as a result of selection bias for healthier people (Hellinger, 1987) sometimes called "the healthy worker bias" (Koebnick, Langer-Gould, Gould, Chao, Iyer, Smith Chen, & Jacobsen, 2012).

Favorable selection occurs when a plan has an enrollee pool whose health care needs are less than anticipated when the premium is set. Adverse selection refers to the opposite situation, that is, when the enrollee pool requires more than the anticipated amount of health care dollars to maintain health. Shane and Trivedi (2012) report insurance bias selections according to employment status, gender, age, ethnic group, education level, income, presence of chronic conditions, and history of previous insurance coverage.

There is documented inadequate insurance coverage for individuals with lower incomes, lower employment status, and bias coverage for same sex relationships (Majerol, & Tolbert,

2016; Gonzales, & Blew, 2014). Senator Elizabeth Warren (D-Mass) (Marans, 2018) identifies further insurance bias by restricting coverage for particular network provider groups and medication reimbursements resulting in narrowing health care access and potentiating adverse health care outcomes on the most basic levels.

The five top U.S. insurance companies are reporting historic profits with cumulative net earnings of $4.5 billion by March of 2017 (Herman, 2017), and third quarter 2017 profits ranging from $446.9 million to $50.3 billion. The insured individual is thus a customer who pays a fee for health care coverage either directly or indirectly to an insurance company. How did the insured individual transition from the customer to an optional entity for an insurance policy?

The Social Security Acts of 1935 and of 1965 demonstrate our government's concern for the elderly, disabled, women and children, and the unemployed (Social Security, n.d.). When did the concern for at-risk populations become secondary to profits? Lastly, how did the situation of the U.S. spending more health care dollars per capita on its citizens, who die at younger ages, and live in poorer health through-out the live span (IOM, 2013) exist alongside insurance companies reporting record breaking profits?

This for-profit industry has morphed the concept of health care from a human experience of promoting best outcomes to an optional inclusion for select individuals in an insurance policy. The insurance industry Wolf Pack approach in health care seeks astounding net profits via:

a) healthy worker selection,

b) limiting coverage to the uninsured and low-income populations,

c) excluding certain network provider groups,

d) limiting medication reimbursements, and

e) targeting the elderly and weak for limited policy coverage.

The Government Wolf Pack

Factors influencing an individual or population's health are called the determinants of health. These include: health and health care services, individual behaviors such as lifestyle choices or habits, social environment status, the physical environment, and genetic determinants. (Kindig, n.d.). Factors affecting health outcomes for diverse populations include: race/ethnicity, geography, gender, and socioeconomic status (Kindig, n.d.). Therefore, health care access improves health care outcomes but requires public policies and programs to distribute the available resources equally for all populations (Kindig, 2017).

Health equity for diverse populations means identifying, within a specified geographical area, respective disparities and the associated morbidity/mortality outcomes with equitable disbursement of resources to achieve the best quality of life. The intersection of a particular population's disparities and health care access determines outcomes. These outcomes differ in an arena of nonexistent or ambiguous public policy versus interactive, strong public policy identifying needs that are matched with equitable resource distribution. A discussion of the individual affecting factors follows.

Costs

Health care is expensive in the United States (U.S.). The cost for national health care expenditures (NHE) increased by 4.3% in 2016, with a total dollar value of $3.3 trillion, representing 17.9% of the Gross Domestic Product (GDP) (CMMS, 2017). This translates to a $10,348 per capita cost in the U.S. (CMMS, 2017), which is three times the OECD expenditure per capita for health care (Peter G. Peterson Foundation, 2017). Health care costs are increasing at an anticipated rate of 5.9% related to increasing Medicare and Medicaid populations (CMMS, 2017). By 2025 the combined cost for public and private health care spending is expected to be one-fifth of the U.S. economy. Despite the high cost of health care, Americans die at a younger age and live in poorer health throughout their lives, compared to other advanced countries (IOM, 2013). Root causes for high health care costs include: low income, being uninsured with limited options for health care access, education level, living environment, and health behavior choices (IOM, 2013).

Racial/Ethnicity, Geographic, Language Health Care Bias

Racial bias in public policy, whether implicit or explicit, is widespread with great potential for negative health outcomes. The End Racial Profiling Act (ERPA) bill H.R. 1498 (2017) was resubmitted for approval in the 115th Congress with bipartisan support of 79 congressional representatives. This bill was first introduced in 2001 (S.989, 2001) and every year since to prohibit racial profiling by any law enforcement agency. This bill also directs all state or government funded programs to eliminate racial profiling and any practices that support racial profiling (S. 989, 2001). In eighteen years, Congress has yet to pass this law. Almost half (41%) of nonelderly Americans are people of color and, as of 2016, 55% of the 32.3 million uninsured nonelderly are people of color (Artega, Foutz, Cornachione, & Garfield, 2016).

There are disparities in access to health care for nonelderly people of color related to cost for services (KFF, 2016). Nonelderly Hispanics (21%), American Indians/Alaskan Natives (21%), and Blacks (13%) have significantly higher rates of being uninsured compared to whites (9%) (Artiga et al., 2016). Barriers in rural health care access are: limited numbers of health care providers, geographic locations with limited Medicaid coverage, and poorer employer-provided health care coverage. There are 60.6 million Americans (21%) over the age of five who are non-English speaking (Wolz, 2014), resulting in language barriers for frontline health care delivery systems with the potential for unintentional noncompliance in costly medical regimens. Limited access to preventive care services for the nonelderly due to economics, color/ethnicity, geographic location, and language has a financial impact of $260 billion per year in loss of employment productivity (CDC, 2017).

Ageism Health Care Bias

In an effort to provide health care for aging Americans, Medicare was established in 1965 by Congress (H.R. 6675). As the Baby Boomer population ages, the Medicare system expects 70 million Americans needing elderly health care by 2030 (Alliance for Aging Research, n.d.). With the problem of ageism prejudice becoming more widely known, it is well understood that elderly health care bias is present and affects this population's ability to live happy, productive lives in their advanced years. According to the Alliance for Aging (n.d.) the following are the issues that need resolution to reverse this bias.

...First, health care providers need additional geriatric training with emphasis in preventive care and screening for age related disease processes.

...Second, age specific disease treatment guidelines need to be adopted that promote better health outcomes for the elderly.

...Third, clinical trials need to include geriatric participants to identify safe drug dosing regimens.

...Lastly, policy makers need to approve health care legislation for low Medicare premiums and deductibles with inclusion of medication coverage as essential elderly health care benefits.

Immigrant Health Care and Solutions

There are 12.1 million illegal immigrants in the United States as of 2014 (Baker, 2018) with an unsustainable taxpayer burden of $17 billion yearly in health care costs that include $4.3 billion spent yearly in emergency departments acting as safety net health care systems (Camarota, 2009). Immigrant reform legislation allowing citizenship provides health care access and reverses the deleterious effects of disparities experienced by this at-risk population. Passel and Cohen (2008) report a projected influx of U.S immigrants to increase by 67 million in 2050 with an additional 50 million immigrant U.S. born children and grandchildren. One solution to this problem is immigrant legislation allowing this population to fund its own health care. The following are additional areas of important consideration.

Technical Feasibility: There are established clinic facilities to provide immigrant health care called Federally Qualified Health Centers (FQHC) (DHSS, 2017) that are under the Medicare/Medicaid federal system. However, access to market place insurance products and options is prevented by government policy due to immigrant status and the associated tax credit restrictions for insurance premiums.

Costs/Cost Effectiveness: Between 2000 and 2011, illegal immigrants contributed $35.1 billion over the actual costs of their health care (Bayne, 2015). Immigrant reform policy utilizing these funds allows frontline provider systems to manage this population's health care in a cost-effective manner. The absence of any immigrant public policy creates a cost prohibitive burden by the U.S. taxpayer for immigrant health care through emergency departments. Public policy motivating insurers to increase health care cost coverage from 60 to 70 cents on the dollar to 85 cents on the dollar and align with Medicare and Medicaid coverage is needed (Marans, 2018).

Value Acceptability: Reversing immigrant inequity of access to health care relieves associated social injustices, protects the health of U.S. citizens, and reduces the high cost of immigrant primary care through emergency departments (CMA, n.d.). The opportunity to access health care insurance results in lower mortality rates, improved opportunities for education and employment, and improved mental health (McConville, Hill, Ugo, & Hayes, 2015).

As stated previously, the Government Wolf Pack approach in current health care policy results in health care access disparities related to race, ethnicity, low income, geographic location, language, immigrant status, and advanced age. Therefore, current health care policy has to confront the problems that arise from the Wolf Pack approach and develop more positive and truly humane approaches so as to achieve that which is ultimately the universally primordial goal, namely increasing and securing the health and well being of all.

In Summary…..

Healthy People 2020 defines health equity as a population that achieves the highest level of health possible (ODPHP, 2017). In other words, health equity is an individual or specific population's ability to achieve the best health possible within their environment with increased years of life associated with a high quality of life (Kindig, 2017). The unchecked disparities in health care translates into preventable health care problems (Whitehead, 2017) and exorbitant costs imposed onto the U.S. taxpayer. Many American leaders have called for needed change. Martin Luther King Jr. said it best:

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

It is leadership's responsibility within the insurance industry and government policy maker groups to avoid Wolf Pack approaches and decision making in health care policy and reform. Providing equitable health care will require creative and fiscally responsible legislation with mandates for equal distribution of resource dollars. Immigrant health care reform policies can provide templates for future health care issues and a vision for solutions to this problem worldwide. The infrastructures exist to achieve an inclusive health care delivery system in the U.S. What is needed is an all-inclusive legislative road map, without the bias of personal agendas and business influences of monetary gain. Ultimately, this requires the commitment of all concerned to inclusive, socially just and humane approaches that support and promote a truly healthy America.

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