Federal Health Policy Response to Hurricane Katrina

What It Was and What It Could Have Been

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ONE YEAR AGO, THE UNITED STATES EXPERIENCED one of the worst natural disasters in its history. Hurricane Katrina caused well-documented, widespread death and destruction, reducing hospital capacity by 80% and safety-net clinics by 75% in New Orleans alone.[1] The hurricane also created a diaspora of more than a million evacuees to every state in the nation.

This disaster could be viewed as an isolated event. Indeed, the hurricane destroyed infrastructure in states with low income and particularly high health care needs. Yet similar crises could occur in different and, unfortunately, likely circumstances. A major earthquake, avian flu epidemic, or bioterrorism attack could diminish health care capacity, cause displacement, and take a great toll on the nation's health. Thus, the federal health policy response to Hurricane Katrina is not just history but a test of the system's effectiveness.

In this commentary, we review the activities of federal officials, critique their performance, and suggest what should be done in the aftermath of disasters, natural or manmade. We focus on the federal government because, in the US democracy, it has the ultimate authority to respond to serious threats or crises. Disasters also call for state and local responses (eg, rapidly assessing need, planning for rebuilding infrastructure). While assessing this response is beyond the scope of this article, its performance contributed to the outcomes described. Special attention is paid to Hurricane Katrina and Louisiana given their size and impact. Our perspective is that of former officials in the federal government who are familiar with both its limitations and its powers.

The Federal Response to Katrina

Traditional Bipartisanship. In the days following Hurricane Katrina, as the devastation in the Gulf Coast was revealed, Congress set out to alleviate the emerging health crisis. As happened after the attacks of September 11, 2001, Congress put aside partisanship to develop "disaster relief" health care policy. The leadership of the Finance Committee, Senators Charles Grassley (R, Iowa) and Max Baucus (D, Mont), introduced the Emergency Health Care Relief Act of 2005 (S 1716) on September 14, 2005. This legislation aimed to provide temporary, federally funded Medicaid coverage to low-income individuals affected by the hurricane, no matter where they sought care. It also would have dedicated $800 million for uncompensated care provided to uninsured hurricane victims. In recognition of the gulf states' higher need and lower revenue, the bill would have eliminated these states' Medicaid financial obligations until December 2006. The Congressional Budget Office (CBO) estimated that this legislation would cost $8.9 billion. It gained support from a large coalition including state, consumer, business, and health care provider groups. Bipartisan governors and senators warned the White House that, if it stood in the way, it risked "a potentially embarrassing political rout."[2]

White House Alternative. Under pressure to respond, the Bush Administration issued executive orders and policy guidance on health care provision for those affected by Katrina.[3] In his speech at Jackson Square in New Orleans, President Bush offered a "disaster relief emergency Medicaid waiver program." This adaptation of an existing demonstration authority gave states the option of financing coverage and uncompensated care for Medicaid-eligible individuals affected by Hurricane Katrina.[4] This waiver policy differed from the Grassley-Baucus bill in 3 major respects. First, its coverage assistance was limited to individuals already eligible for Medicaid; it did not help those who lost their jobs, were poor and displaced, or developed health problems. Second, its funding was capped based on prenegotiated waiver agreements; it was not based on need. And third, funding was not guaranteed; Congress still needed to act to offset states' costs of caring for evacuees.[5]

Shortly after the release of this policy in September, the Bush Administration opposed the bipartisan Grassley-Baucus legislation. It expressed concerns about its relevance, bureaucracy, ability to be implemented quickly, and costs.[6,7]

See also p 1333.

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Budget Backlash. The Bush Administration's opposition to the legislation was welcomed by a small but vocal group of conservative Republicans who questioned the hurricane relief.[8] As Sen John Sununu explained, "We do not want to create a future economic catastrophe in our heartfelt efforts to deal with this natural disaster today."[9] By the end of October, the fiscal conservatives prevailed, despite the bipartisan legislation's widespread support. Sen Grassley folded significantly scaled-back assistance into the budget reconciliation bill. The House policy was slightly more generous. Both versions maintained the essential structure of the Grassley-Baucus bill but limited the eligibility, duration, and uncompensated care funding. The Senate version would have cost an estimated $1.8 billion while the House version would have cost $2.5 billion, according to the CBO. Both bills passed largely along party lines in November 2005.

The White House opposed even these constrained versions of the Grassley-Baucus bill.[10] As a result, the legislation that emerged from the budget conference in December included a Hurricane Katrina policy that was entirely different than that of the House or Senate, but conformed to the White House policy. It gave the Department of Health and Human Services (DHHS) a $2 billion block grant to allocate, at the secretary's discretion, to states that had approved Hurricane Katrina waivers. Because of a technicality, the bill did not become law until February 1, 2006.

Attenuated Action. By early 2006, the focus on the gulf states' health problems had diminished. The president did not mention the Hurricane Katrina health provision at the signing of the budget legislation. Moreover, the administration did not allocate the block grant funding until March 24, 2006, and then, it provided states with $1.5 billion of the $2 billion appropriation.[11] As of August 25, 2006, the remaining $500 million from the fund had not been allocated. No public explanation has been provided for these delays. In addition, rather than traditional public health programs, general state block grant authorities were used to direct funds to the gulf states.[12] Neither the president's 2007 budget nor his emergency supplemental proposal for Hurricane Katrina relief included additional DHHS funding to assist with health care needs in the gulf states.

Assessment

Elements of the federal response to Hurricane Katrina deserve praise. For example, the US Public Health Service and military effectively provided needed emergency services. Secretary of the DHHS Michael Leavitt dedicated time to a planning process for redesigning the health system in Louisiana. The efforts of Senators Grassley and Baucus probably increased the ultimate funding for health coverage for individuals affected by the hurricane.

However, there were 3 major faults in the federal response. First, the assistance provided by Congress and the White House was inadequate to meet the immediate and subsequent need. According to the CBO, more than 2 million people from affected areas were receiving or became eligible for Medicaid. Many more likely became uninsured: one study of individuals in shelters found that about half lacked health insurance coverage.[13] The Hurricane Katrina waivers, by design, assisted only individuals who met narrow Medicaid eligibility guidelines, not low-income individuals who lost their insurance or who used the public hospital system in New Orleans. The policy only partially compensated hospitals and other providers for care for uninsured evacuees. The amount appropriated, $2 billion, could not, under the best of circumstances, provide coverage to the roughly 3 million people in need.

Systems as well as patients suffered. Dedicated funding was neither sought nor appropriated in 2006 to shore up local physicians' offices, clinics, hospitals, and nursing homes. For example, community health centers, which cared for large numbers of uninsured individuals after the hurricanes and sustained $65 million in physical damage, received no additional appropriation.[14] Irrespective of how local and state policy makers decide to rebuild their health systems, it will cost more to start from a system diminished by attrition than one maintained during the transition with the help of federal funding.

Second, even if Congress and the Bush Administration were to dedicate significant resources to the gulf states today, it may be too late. The long period of uncertainty before funding was secured reduced states' willingness to help hurricane evacuees. They were assimilated into communities nationwide, often at diminished standards of living. Moreover, large numbers of individuals in affected areas lost their jobs and health insurance. The lack of health coverage may have contributed to irreversible problems. For example, the death rate in New Orleans appears to have been higher in the months since Hurricane Katrina.[15] A recent review found significant mental health problems, including elevated suicide rates, resulting partially from limited service availability.[16] Nearly half of parents in Federal Emergency Management Agency–subsidized housing in Louisiana reported that their children have experienced emotional or behavioral difficulties.[17]

The delay in federal assistance as well as the use of emergency personnel and waivers may have slowed the recovery of the health system and the economy in the gulf states. As of August 2006, there was neither a Louisiana-designed plan for its health system nor dedicated federal financing to help create it. One physician called the system "unacceptably primitive."[18] The failure to quickly rebuild levees, provide a housing plan, and restore general as well as health care infrastructure has led clinicians as well as the individuals they serve to move from the area. The reverse is true as well: the shortage of health facilities and clinicians probably has altered the repopulation of affected areas. While state and local leaders share the blame, federal inaction to sustain the health system contributed to these problems that have damaged what infrastructure survived the storm.

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Third, the federal policy response highlighted flaws in the decision-making process. The White House's early and insistent desire for control of the policy delayed the inevitable need for congressional action. Conservatives not only lowered funding but diverted it through mechanisms (eg, block grants) that are less accountable than existing programs. As is all too common currently, a few senators blocked legislation that had the support of the majority. These problems are not the result of partisan tensions since they occurred under single-party rule. In part, they reflect the injection of ideology into policy. Support for small government and opposition to entitlements blocked policies that could have quickly and effectively helped residents of the gulf states. More important, they spotlight the lack of established policy tools to rapidly deliver health care in the aftermath of a catastrophe.

Building a Health Crisis Response System

The US response to Hurricane Katrina should have demonstrated to those directly affected, the nation, and the world the strengths of the US government. While many of the government's powers are local, assurance of security and equity rests at the federal level, especially when disasters cross state lines. The president and Congress have a duty to act immediately and aggressively in emergencies. This happened in New York after the attacks of September 11; it should have occurred in New Orleans last fall. Citizens of New Orleans are Americans first. We propose policies that could have resulted in improved health and health care delivery following the hurricane. If enacted, they would help to improve the national response to future shocks to the system. These draw on several solid ideas that have been proposed in the wake of the hurricane.[19-21]

Executive Actions. As veterans of DHHS and the Office of Management and Budget (OMB), we appreciate the power of the executive branch. President Bush could have immediately waived program rules to facilitate access to care. He could also have reprogrammed or redirected funding and stepped up efforts to locate and keep clinicians in affected areas. DHHS and OMB could have acted on a Medicaid waiver for Louisiana that would have redirected unspent Medicaid disproportionate share hospital payments to other facilities, community-based care, and coverage. To prevent bureaucratic inertia, a standing cross-agency council, led by the DHHS but including OMB and the Department of Homeland Security, could be created to marshal health policy resources during crises. Its lines of accountability and powers would be delineated in advance, providing the agency with tools to stem the flow of damage during disasters.

Budget Policy. The Bush Administration and Congress could have appropriated funds for public health programs to meet the gulf states' need, either directly or through the Public Health and Social Services Emergency Fund. This fund has been used for past hurricane relief (eg, Andrew) and avian flu preparedness. The secretary can allocate its funds to agencies for specific programs—for example, mental health programs and policies to ensure access to health care. Generally, the executive branch and Congress could keep a reserve in this emergency fund for disasters. If unspent, the funds would revert to the Treasury, but having it available would enable flexible and rapid investments after catastrophes.

Medicaid Policy. A central part of a response to any disaster should be ensuring health coverage, which is essential to access to care. The Grassley-Baucus bill would have provided such coverage through Medicaid to all low-income and disabled individuals affected by Hurricane Katrina, although today, its 5-month time limit seems inadequate. Other policies like a buy-in to the federal employees system could also be a component of a long-term response. For future disaster preparedness, Congress should enact a permanent, emergency Medicaid authority. Medicaid has the eligibility and payment systems in place to quickly extend coverage to broad or targeted groups. Fully funded, temporary expansions could be triggered by legislative criteria or an executive agency designation. This would create a health insurance safety net that would help not only low-income but all individuals whose system would be strengthened by the financing of care during crises. It could also protect the public's health by removing financial barriers to prevention and containment among individuals exposed to contagious diseases.

System-Wide Reform. The gaps in the health system and health policy response revealed by Hurricane Katrina were not simply caused by it. They are symptoms of a broken system that affects millions of Americans. About a third of Americans are uninsured or underinsured; access is rationed by financing and poor planning; and health care providers struggle to operate in a complicated system not geared toward quality. This is a silent crisis that affects not only the safety of the US population but the strength of the economy.

Perhaps the most sobering lesson from Hurricane Katrina is that even incremental, temporary, rational, and bipartisan responses to crises are difficult to achieve. The federal policy process has become slow and easily derailed, preventing the nimble response demanded by the threats and challenges of the 21st century. The only way to truly prevent the policy-induced problems highlighted by Hurricane Katrina is to reform the health system, making it accessible, affordable, and quality-oriented for all.

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Terminal Withdrawal of Life-Sustaining Supplemental Oxygen

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An influential report released in 1983 defined life-sustaining therapies as "all health care interventions that have the effect of increasing the life span of the patient."[1] This definition is highly inclusive: aspirin for stable coronary artery disease, intravenous antibiotics for osteomyelitis, and mechanical ventilation for respiratory failure all qualify. However, when considering withholding or withdrawing life-sustaining interventions, clinicians commonly refer to a more discrete group of therapies intended to forestall impending death by augmenting or replacing a vital bodily function. A hallmark of life-sustaining therapies, therefore, is that withholding or withdrawing them leads to physiologic decompensation foreseeably to cardiac arrest.

Supplemental oxygen has not commonly been considered a life-sustaining therapy. Yet it clearly serves this purpose for spontaneously breathing patients in whom pulmonary gas exchange is so impaired that the needs of vital organs cannot be met with ambient air alone. Supplemental oxygen may be lifesaving, as in the acute treatment of severe pneumonia or pulmonary embolism, or life-sustaining, as in the subacute or long-term management of patients with advanced pulmonary fibrosis, extensive intrathoracic cancer, or cardiovascular conditions causing right-to-left shunting of venous blood.

As cardiopulmonary diseases associated with hypoxemia increase in incidence, and as new technologies are available to provide high-flow oxygen to patients living at home, physicians are more commonly caring for patients whose lives are sustained by supplemental oxygen. Although improvements in oxygen delivery systems have led to improved functional capacity for some patients, the quality of life associated with long-term oxygen dependence may remain unacceptable. As a result, some patients have asked their physicians for assistance with or acquiescence to their plans to withdraw supplemental oxygen.

Informed patients with decision-making capacity have well-established rights to forgo any and all forms of life-sustaining therapy.[2,3] Although these rights clearly extend to supplemental oxygen, requests to remove this form of life-sustaining therapy raise difficult questions. Should physicians help patients remove such a minimally invasive and

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