Gerald Faverman, Ph.D. • *Chairman of the Board*
Robert J. Kleine • *Editor*

Public Sector Reports

Michigan **COMMENTARY**

A Naive and Immodest Proposal

By Peter Pratt, Senior Consultant for Health Policy

With the election of Bill Clinton, the partisan gridlock that has paralyzed federal leaders promises to end. Substantial health care reform is on the horizon, we are told.

While one would like to think it so, numerous postelection assessments are dismaying. The relentless contradictions in health care continue unabated: A recent headline from *The Wall Street Journal* reads "Preventive Care Is Prescribed to Cut Costs, but Doctor Training Faces Scalpel." Writing in *The New England Journal of Medicine*, noted health policy analyst Eli Ginzberg laments that all the stakeholders in health care—patients, public and private payers, insurers, and providers—have more invested in the status quo than in any proposed change in the system. Better that all players remain subject to capricious regulation, appropriation, and reimbursement than that rational reform disadvantage some special interests more than others. The virtue of random, piecemeal changes in health care policy is that everyone can justifiably assert that the system does not serve patients well while guarding their interests against meaningful reform that would serve patients better.

"WHILE ADMITTING PRIVATELY..."

The most frustrating aspect of this opposition to meaningful change is that all the stakeholders will admit privately that we desperately need health care reform. These off-the-record comments are not steeped in generalities, either. There is a remarkable degree of agreement on the specific pieces of health care reform: more primary and preventive care, less inappropriate care, more provider accountability, insurance market reform, medical liability reform, universal access, rational cost containment. How many other major policy issues can claim so much common ground? Such is the nature of the debate, however, that private admissions give way to public denunciations and common ground gives way to partisan squabbling.

THE FALSE DICHOTOMIES OF THE HEALTH CARE DEBATE

Common ground is difficult to maintain when false dichotomies rule the debate and distract us from the central issue, caring for individual patients and populations. For too long the health care debate has been framed in stark economic opposites—the market vs. government regulation—that bear little relevance to the health care system as we know it. Our health care system will never be a pure model of anything, and the sooner we abandon the attempt to make it pass the litmus test of one ideology or another, the sooner we can move on to caring for patients.

Another misleading dichotomy—health care as a business vs. health care as a calling—also paralyzes the debate. Payers pummel providers with the demands of good business, efficiency, and accountability without understanding fully that patients are not widgets assembled on the line. For their part, providers cry out that they should have the clinical equivalent of academic freedom, caring for whomever they choose in whatever way they alone deem necessary. Neither is right and neither is wrong; of course, as everyone will admit privately, the truth lies somewhere in the middle. In some settings recently, payers and providers have shared their perspectives, with a genuine eye toward mutual understanding and patient benefit. One cannot help but fear, however, that the old divisions will reappear as the health care debate intensifies.

Public Sector Consultants, Inc.
Knapp's Centre • 300 S. Washington Sq. • Suite 401
Lansing, MI 48933-2134 • (517) 484-4954

The third false dichotomy is the most problematic and controversial: health care as a right vs. health care as a privilege. This is perhaps not so much a dichotomy as a gulf between theory and practice. The problem with the focus on health care as a right is that discussions of rights quickly become abstract and detract from efforts to insure the means of giving life to the right. Rights are meaningless if we lack the will and resources to exercise them. Now, the right to health care is like the "right" to land on the moon: Sure we have the technology, but only ten people can afford it. We are in a no man's land between declaring and guaranteeing this right. In the meantime, health care is becoming a privilege.

The focus on the rights of individuals to health care obscures the *collective* health care needs of our population and any rational attempt to address them. Many of our present problems stem from the mindset that the right to health care is the right to unabashed overuse of health care resources, with little attention to whether the patient needs it. Those with health insurance have the right to too much health care and those without insurance have the right to too little health care. This failure to address our collective needs helps explain why, day by day in the waning years of this millennium, more and more individuals are losing, with little or no recourse, the jobs and health benefits that secure their right to health care.

THE PATIENT ADVOCATES

Most special interests in health care claim to be patient advocates. In one fashion or another, they declare that their efforts are intended to help patients. As cost and access problems have escalated in recent years, the entrenched interests, fighting for their own lives, have less time for patients. Even most patients are poor patient advocates: They don't take care of themselves, they do things they know they shouldn't, and they admit privately that the problems in health care began only when they themselves—not their less fortunate neighbors—started having trouble paying for health insurance. Few patients see the enlightened self-interest in having everyone become healthier. Sadly, no one group can lay claim to the esteemed title of patient advocates.

A NAIVE PROPOSAL

The details of reform are very important, but the soul of reform is the key to meaningful change. Self-interest must give way to patient interest and responsibility. False dichotomies must no longer color assessments of our true needs and the means of meeting them. Deliver us from task forces in which representatives from all the special interests sit down together and hash out a moribund compromise. We must, as Robert Bellah has noted, distinguish compromise from the common good. The former balances special interests, which we erroneously assume leads to good public policy; the latter promotes the general interest. Let us have policymakers bring to the light of public discussion all those beliefs that they hold dear only in private. Let us have them bring their knowledge not their bias to the table. Let us have true coalitions, in which mutual understanding is not an end in itself but a major step toward the common good.

It is obvious that all the stakeholders must sacrifice if we are to have sound reform. It is equally clear that some will have to sacrifice more than others, although the particular fallout is not set. Who will be the first to advocate for a reform that is not self-serving? Who will become the true leader in health care reform in this state and in this nation? Who will earn the high moral ground that must provide the foundation for humane change? Some of us have faith that others will follow suit once that first person, that first organization crashes through the wall of conventional politics. Sacrifice follows sacrifice, just as self-interest engenders more self-interest. Who will be the first to become, in Vaclav Havel's resonant epithet, "ambassadors of trust in a fearful world"?