Gerald Faverman, Ph.D. • *Chairman of the Board*
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HEALTH POLICY BULLETIN

FOCUS: JOINT ECONOMIC COMMITTEE REPORT

The Subcommittee on Education and Health of the Joint Economic Committee of the U.S. Congress recently released its report, "The Future of Health Care in America." The report's summary states flatly that American health care costs are driven by five factors: "excessive waste, overutilization of technology, skyrocketing malpractice insurance premiums, patient attitudes that more tests and procedures are better than less, and a pluralistic approach in which wide ranges of choice on all aspects of health care are considered essential." This report is important because its recommendations represent a consensus of congressional leadership and health policy experts about the need for a major overhaul of the American health care system; sixty-eight witnesses testified before the subcommittee on eight issues ranging from health care costs and trends to medical malpractice insurance.

Vast quantities of statistics were presented. Among the most graphic and startling were those showing that health care costs in the United States have risen from **a billion dollars a month** in 1950 to **a billion and a half dollars a day** in 1988, that 20 to 30 percent of medical procedures performed may be unjustified, and that 60 percent of all deaths are premature. The report indicates that health care system costs could be significantly reduced without sacrificing the quality of care by eliminating **$125 billion** in unnecessary tests and procedures, reducing the paperwork that accounts for **$20** of every **$100** spent on health care, and changing behaviors and providing primary preventive care to all to reduce the **$200 billion** a year in health care expenses and lost income lack of such care currently costs.

The report came out with nine recommendations. Some are controversial—moving toward national health insurance in the Canadian style is sure to face considerable opposition from physicians and patients in this country. The report notes that adoption of such a plan might reduce the average income of physicians, but that the use of a fee schedule negotiated between the physicians and the payer (the government) would eliminate the complexities of the present system. Robert G. Evans, Ph.D., professor of economics, University of British Columbia, says, "(1) Universal coverage *is the means* for getting costs under control, and (2) there is no tradeoff between universal coverage and cost control—the two are complementary." A second recommendation, Medicare payment reform via a resource-based relative value scale linked to expenditure targets, has been adopted; physician payments under Medicare Part B are expected to rise no more than 9.1 percent in 1990.

A third recommendation, the development and application of standards of care derived from outcomes research to cut down on unnecessary tests and procedures, is relatively noncontroversial. Andrew Webber, executive vice-president, American Medical Peer Review Association, notes that integrated databases, objective clinical data, longitudinal outcome studies, and clinical guidelines and standards will be needed to curb the overutilization of technology and procedures that adds several billion dollars annually to costs (200,000 of the 250,000 coronary bypass operations performed every year at an average cost of $25,000 per operation are estimated to be unnecessary; at least half of the 900,000 Caesarean sections and 120,000 pacemaker implants are considered unnecessary or questionable at an annual cost of $2.28 billion).

Three recommendations are focused around patient attitudes, the importance of prevention to health, and changing the focus of the health care system from episodic sickness care to health promotion. "Patients must learn that not all procedures and/or treatments are cures.... Patients must not expect to be 'treated' for every condition." Joseph Califano, former secretary of the U.S. Department of Health, Education and Welfare, has suggested that paying doctors to talk to patients and to persuade them to spend dollars for counseling is a necessary first step in reeducating patients. Related to reeducating patients is health prevention; at most, 4 percent of our health care dollars are spent on health promotion and disease prevention. Besides the need to change lifestyles to reduce the incidence of cardio- and cerebrovascular disease and cancer, the other great needs, according to the report, are reducing teen-age pregnancies and increasing research on the effectiveness of health promotion and prevention measures with the elderly. Wellness or primary care clinics should be located where they would be most accessible: at schools, senior citizen and shopping centers, and worksites. Screening for major diseases and alcohol, drug, and nutrition counseling should be routine.

Reordering our research priorities is particularly important for the elderly: Major threats to their independence include incontinence, memory loss (dementia), and immobility (arthritis). These three conditions result in annual costs of about **$60 billion**, yet less than **$200 million** is spent on research in those areas. This is especially important because population estimates suggest that **39 million** Americans will be over age 65 by the year 2010. The report estimates that a one-month reduction in the average period of dependence could produce annual savings of as much as **$4 billion**.

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

Medical malpractice liability received its share of attention. Hearing participants suggested that reforms to improve the administration of the judicial system are needed, and that administrative boards and methods of alternative dispute resolution need to be employed. Malpractice premiums rose to **$4.7 billion** in 1985, and defensive medicine is estimated to add **$10.6 billion** per year to health care costs. It is noteworthy that the list of witnesses testifying before the hearing on that issue does not appear to have included any significant patient advocates.

The final recommendation outlines four areas of activity for the federal government: promotion of ethics education (increasing patients' awareness of their options, enabling patients to make their own decisions, and avoiding "bedside" rationing by providers), setting standards for living wills and durable powers of attorney, changing Medicare payments to pay for supportive care for the terminally ill patient, and increasing funds for research. Giles R. Scofield III, staff counsel, Concern for Dying, asked that the federal government require "residency training programs to educate physicians regarding the law on the patient's right to refuse or withdraw from treatment." Joanne Lynn, M.D., acting director, Center for Aging Studies, George Washington University, suggested that Medicare regulations be changed to prohibit payment for hospital care "which is prolonged by hospitals seeking court orders where physicians and family are in agreement to terminate a patient's life-support system."

FOCUS: REACTION TO "MANAGING MICHIGAN'S HEALTH CARE COSTS"

Last month we printed a summary of the report by the governor's health care cost containment team. This month we would like to share with you some reactions to the report.

Charles Ellstein, group vice-president, Health Care Delivery and Finance, Michigan Hospital Association (MHA), took issue with the recommendation for an all-payer DRG system, saying, "We'll talk about an all-payer system if it is a real all-payer system and everybody pays their share." The MHA also has concerns about the issue of changing cost-based capital reimbursement in the Medicaid program to some other system. The MHA has interpreted the recommendation to mean that hospitals with certificate of need approvals granted by the Michigan Department of Public Health could be denied reimbursement for capital costs by the Medicaid program; in its view, to be subject to the vagaries of two systems (CON and market-based competition) is unfair.

Mary Anne Ford, chief of state government affairs, Michigan State Medical Society (MSMS), shares a concern with the MHA about referrals for ancillary services to facilities or institutions in which the referring party has a financial interest. Ford noted that all such referrals are not inappropriate, citing the cases of HMOs and PPAs where referrals are made to entities with contract arrangements with laboratories.

Louis Sesti, executive director, Michigan Pharmacists' Association, explained that he was not personally offended by the Steering Committee initiative that recommended the development of a state formulary for use by state employee health plans and the Medicaid program. (The Medicaid program has been trying to get a closed formulary for the past few years as a way of reducing its drug costs.) He did note that that recommendation had not been in the final report of the Delivery Effectiveness Work Group. A closed formulary, according to Sesti, is really a preferred product list and adds an "educational dimension to prescribing that has an economic result"; that is, both physicians and consumers become more aware of the cost and efficacy of various drugs. He noted that the pharmaceutical industry has been moving in this direction and was confident his membership could work with preferred products rather than mandated products.

OF INTEREST

The legislative schedule for January is light; both houses will recess following the governor's State of the State address. The House will come back on Thursday, January 16, and the Senate will return on Tuesday, January 23. It is unlikely that any legislation still in committee will emerge before February. The legislature probably will mark time until the executive budget is presented on February 23 when the budget process will begin to dominate legislative activity.

The Certificate of Need Commission will meet on February 20 at the MSU Student Union Building in Parlor C at 10:00 a.m. At this writing the commission's agenda has not yet been set.

It is likely that the publication of the governor's cost containment report has stolen the thunder of the Governor's Task Force on Access to Health Care. The earliest possible date for the release of the latter's report is now March, which makes it six months late. A drafting committee composed of task force members has been appointed and has written a draft; another meeting of the entire task force will be necessary to approve the draft.

—Frances L. Faverman, Editor