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January 14, 1991

HEALTH POLICY BULLETIN

FOCUS: SEN. PRIDNIA AND HEALTH POLICY

First-term state Senator John Pridnia, the new chairperson of the Senate Committee on Health Policy, is well-versed in health issues. During his eight years in the House, he served as a member of the House Committee on Public Health and as minority vice-chair during the 1989–90 session. He also attributes his familiarity with health issues to his wife (a registered nurse who supervises home health workers for a multicounty home health services agency), to his parents' experience trying to gain access to health care services in rural Michigan, and to his own experience as a small businessman trying to provide health care coverage for employees.

In an interview in December, Pridnia emphasized that he "is not a rural chairman." (He was born and brought up on the east side of Detroit.) He made clear that while he supports much of Governor Engler's health care agenda, he has his own. He noted that one-third of the people in his former House district were classified as working poor. "My goal is to see to it that health care is available to all people of all incomes." How to accomplish that? "Treat urban and rural areas equally but recognize that the design needs to be different. For example, geography. Standards for home health care services need to take into account the greater distances that have to be traveled in outstate areas because the population is more widely dispersed," he observed. He noted that when his parents moved up north, they were overwhelmed by the difficulty of gaining access to necessary health care.

Asked what the probable effect of the state's budget crisis will be on health policy, he said that "we can't waste time on programs designed for politics, like Healthy Start. We will have to prioritize first, second, and third needs and forget the rest." He would like to see the health care industry identify its common goals and make changes, then have the legislature evaluate them. He intends to work for and with the Michigan Department of Public Health while supporting an overhaul of the department.

Two major issues for providers and insurers are further tort reform for medical liability and some form of limitation on provider fees paid under no-fault auto insurance. The Michigan State Medical Society, the Michigan Hospital Association, and the Michigan Association of Osteopathic Physicians and Surgeons want more tort reform. Although Pridnia agrees that more needs to be done, he is not entirely pleased with what he described as the "parochialism" of the various parties. He does not see wholesale change taking place; he would like all parties to find a center point and indicated a willingness to be "hard-nosed" about the compromises groups would have to accept to get more tort reform. Pridnia does support limiting the fees auto insurers have to pay providers—he was a sponsor for HB 5317, the House Republican version of a bill to use the workers' compensation fee schedule for provider reimbursement for auto-related injuries and to establish limited medical benefit options under no-fault auto insurance.

Certificate of need regulation, he feels, can be eliminated in some areas, but overhaul and realignment of the CON process is much more likely. Such items as the facility placement of magnetic resonance imaging and sound home care and hospice programs are important to him. Pridnia would like to see the development of a "health care caucus," a group with common agendas to improve the quality of care and restrict the growth of costs.

The following is a summary of Senator Pridnia's recent health care legislative record. In the 1987–88 session, he was the primary sponsor on 15 bills; two concerned health issues. HB 4417 would give the governor emergency powers in food and drug tampering situations, and HB 5536 would make failure by a person with AIDS to inform a sexual partner of his or her condition prior to sexual penetration a felony. Neither measure became law. In the 1989–90 session, 21 bills carried his name as the principal sponsor; 8 were related to health care. Of those bills, four became law. HB 5131 (P.A. 271 of 1989) created an exception to the confidentiality of medical records for children with AIDS being placed in foster homes; HB 5412 (P.A. 226 of 1990) made technical amendments to the Michigan Public Health Code that allow the department to determine the level of coverage for basic health services through statistical techniques other than sampling the population. HB 5568 (P.A. 216 of 1990) established oral pathology as a new dental specialty, while HB 5652 (P.A. 138 of 1990) created the Office of Rural Health jointly operated by the MDPH and Michigan State University. The four remaining bills proposed licensure for speech pathologists and audiologists (HB 5748), income and single business tax credits for persons and corporations donating to the Michigan Child Caring Program (HBs 6075-6076), and allowing the private sale, discounted sale, and/or issuance of term bonds by hospital authorities (HB 6074).

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FOCUS: "AUX ARMES, CITOYENS!"

One could almost hear echoes of that famous cry as Leland Kaiser, Ph.D., speaking before an audience of 300 people at The Citizens Symposia, a lecture series sponsored by the Citizens Insurance Company of America, proclaimed, "Redesign [of the health care system] is a radical act." The white-haired Kaiser attacked vigorously many of the sacred cows of twentieth-century medicine. Paraphrasing the early twentieth century French statesman Georges Clemenceau ("War is too important to be left to the generals."), Kaiser implied that health and health care are too important to be left to the health care industry; citizen involvement is a must.

He said, "When Humpty Dumpty falls off the wall, that is the death of medicine. When we put it together again, that is the beginning of health." What we need to do, he continued, is to redesign the health care system. In his view, design is a function of the answers to three questions: What is something supposed to do? What is the mechanism for doing it? How much will it cost? Kaiser called the 1990s an exciting and challenging time in which to practice citizen-based design.

Who should redesign the system? Business, industry, and citizens. Citizen-based redesign of the health care system would feature collaboration rather than competition or regulation. According to Kaiser, "We could save 30 to 40 percent of the money we spend on health care if we redesigned it. Competition and regulation are strategies, he says, that do not lead to empowerment of the community, rather they limit its power. However, he notes there are obstacles to collaboration: traditional mindsets, an unwillingness to gore one's own ox, and federal antitrust laws.

Rationing is not the answer to cost containment, says Kaiser, because it permits a one-time-only purge of the excesses in the system. He mentioned both Oregon and Michigan in this connection: Rationing as a solution to containing health care expenditures in Oregon will be good for about seven or eight years and merely postpones redesigning health care. Michigan's budget "turbulence" will probably propel us in a similar direction with similar results. Our real problem is not the amount of money we spend on health care but how it is allocated, which is why competition is not an effective strategy. When hospitals compete in offering identical services in the same market, they spend (or allocate) resources unwisely; if the resources were devoted to specific, different services offered noncompetitively, more services could be made available to more people for less money. However, we would have to change the way we think about competition for such events to occur.

Dr. Kaiser noted that our medical care is splendid; our failures are in health care. He pointed out the differences between the two types of care. "Medical care," he observed, "is about curing, while health care is about healing and caring." The hospital of the future will be both a high-tech and a high-touch facility, devoted to health care as much as to medical care.

One of the failures of our health care system is that it does not distinguish between human events, such as birth and death, and their medical components. For Kaiser, death is another stage of life and is not necessarily something to be staved off. Our ability to prolong life has led to situations "where what we do to people in our intensive care units surpasses anything medieval torturers were able to do to people." Neither birth nor death is a medical event; instead, each is a human event having a medical component. Thus, each should take place outside a clinical setting if at all possible, a sentiment that, if acted upon, would save billions of health care dollars. Genetic engineering, and its possibilities for removing diseases, and genetic therapy will result in lifespans of 120 or more years and will raise new questions about our attitudes toward death.

Kaiser also stressed social accountability: "Making systems work is called social accountability." Licensure of health care professionals and facilities does not ensure accountability, but performance certification does. He thinks providers, rather than being licensed, may in the future be certified for performing particular procedures (how performance certification would be monitored was not addressed).

OF INTEREST

Following the swearing-in ceremonies, the legislature adjourned. The Senate will return on January 24th and the House on January 31st; the top priorities will be voting on the raises proposed by the state's officeholder compensation commission and then cutting the state's budget by another half-billion dollars. Cuts in Medicaid payments to hospitals would appear to be prohibited by the terms of the agreement reached between the state and the Michigan Hospital Association and submitted to Judge Robert Holmes Bell.

The Utah Tax Commission has published guidelines for determining the tax-exempt status of nonprofit hospitals. Continued exemption from property taxes is tied to charity care given by the institution—the value of charity care must at least equal the amount of property taxes the facility would pay were it not exempt. Expect interest in this topic to develop in Michigan as hard-pressed local governments look for ways to increase revenues and an increasingly cynical public continues to question the social value of tax exemptions.

—Frances L. Faverman, Editor