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

FOCUS: PURSELL ON HEALTH CARE

In a recent interview, Representative Carl D. Pursell, Michigan 2nd Congressional District, talked about health care policy and his views of the future in this election year. Now in his 16th year in Congress, Pursell is the ranking minority member of the House Appropriations Subcommittee on Labor, Health and Human Services, and Education (LHHSE). Pursell is the first congressman from either party in Michigan's delegation to become a ranking member of LHHSE.

The subcommittee oversees the appropriations for the U.S. departments of Health and Human Services (HHS), Education, and Labor. Within HHS are programs such as Social Security, Medicare, the National Institutes of Health, Community Health Centers, the Centers for Disease Control, the National Health Service Corps, the Older Americans Act, AIDS research, and Maternal and Child Health and Resources Development (which concentrates on infant mortality, a significant issue in Michigan). His position on the committee gives him a considerable say in how approximately $50 billion in discretionary spending is appropriated. His subcommittee also is responsible for about $200 billion in spending on entitlement programs.

Pursell foresees a stormy year, not only because it is an election year and incumbents are concerned about the term limitation movement as well as the normal battles, but because "national health insurance is a legitimate national issue." He does not foresee any action on health care until after the election. He is concerned also about the role health care benefits may play in upcoming labor negotiations. Agreements covering communications, construction, and airline workers expire this year; health benefits are expected to be a major issue in negotiations of new contracts. He noted that labor leaders and corporate executives have begun to merge their points of view, a reference to a proposal put forth by the National Leadership Coalition for Health Care Reform that would set an annual health care budget and uniform rates for all health care services.

Of the fifty or so proposals in the Congress for some form of national health care reform, he likes most the proposal put forth by Representative Nancy Johnson (R-CT). That proposal is a market-based reform plan that would provide basic acute care benefits and preventive care and would use managed care, malpractice reform, small business insurance reform, and reduced benefit mandates to control costs.

True to his Republican roots and principles, Pursell would like to see a market reform plan pass Congress, but when asked which proposal he thought most likely to be approved, he said, "a plan that combines some elements of market reform with the major features of the plans put forth by Senator Mitchell and Representative Rostenkowski." Rostenkowski's and Mitchell's plans both feature universal coverage, mandated basic benefits, protection for low income persons, caps on national health expenditures, negotiated payment rates, managed care, administrative simplification, and small business insurance reform.

Leaving aside the problem of how to blend together plans that provide universal coverage with those that do not, Pursell says he wants a plan that accomplishes three objectives: "Provides as many options in the private sector for the consumer as is possible, makes sure that competition is in the system, and allows waivers for states to experiment with Medicaid programs. I think this [experimentation] is a healthy process for states."

It comes as no surprise that "a totally federally funded Canadian or British plan" is unacceptable to him. He is firmly opposed also to committing himself on some form of health care reform until he sees how it will be financed. Despite his opposition to total federal funding, he is willing to combine some market-driven programs with federal financing. His best guess about financing right now is that it probably will be a combination of beneficiary plus employer payments.

Chief among the problems that impinge on the ability of policy makers to make a decision about health care is the existing federal budget deficit of almost $400 billion. Pursell speculated that perhaps $50–80 billion could be found in the defense budget. "But, then," he asked, "where does it go? To entitlement programs, education, or to [reduce] the deficit?"

FOCUS: A NEW KIND OF PRIMARY CARE PHYSICIAN?

Despite the tremendous need for primary care physicians, few medical schools and their teaching hospitals are interested or successful in graduating them. Two of the best regarded programs for training primary care physicians are at Michigan State University—the colleges of Human Medicine and Osteopathic Medicine. The College of Osteopathic Medicine (COM) is seriously examining a new way to educate primary care physicians.

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

The model proposed by Douglas Wood, D.O., Ph.D., Dean of the COM, would compress the traditional four years of medical school, one-year rotating internship, and two-year residency in family medicine into six, possibly six and a half, years. According to Wood, one of the problems with current system is "the box theory of medical education." That is, medical education is divided into stages or boxes, each having at best a tenuous relationship to its predecessor or successor; pre-clinical education in the basic sciences has little relationship to the clinical education that follows, and the internship has little connection to the residency experience. Wood would like to join undergraduate and graduate education in a "true educational continuum" so that at the end of six years the osteopathic medical student would have both the D.O. degree and specialty certification. (This approach depends heavily on what is known as the "single agent theory of medical education" under which the medical school rather than the teaching hospital would have the chief responsibility for providing graduate medical education.)

Some curriculum revision would be needed, but the principal change would be in the way medical students are taught, a process that has already begun at COM. Medical education, says Wood, needs to focus on teaching a basic core of knowledge that every physician must have instead of presenting every known fact about the body; e.g., every physician has to know where the kidneys are located, but the facts about how to treat kidney ailments will change with new research; the student, instead of learning a body of facts that will be outdated shortly, should concentrate on learning how to gain access to the new information about the kidneys. By integrating the basic and clinical sciences in the teaching process students will be able to see how basic science information relates to clinical needs. Wood notes that in his own specialty (nephrology) he team teaches with a physiologist so that students have the opportunity to relate concepts about disease to treatment. Keeping an artificial distance between concepts learned in the basic sciences and the application of those concepts to the treatment of disease is outmoded, he believes.

The current generation of physicians, according to Wood, generally does not have computer skills; he would make teaching students how to gain access to information through the use of computers and databases a high priority. For most of his or her working life, the physician who is educated today will need to rely on information and skills learned after the formal medical education experience. He notes that not only will the half-life of a medical education be about two and a half years by the year 2000, but also the emphasis will have changed because of the tremendous strides being made in cellular biology. Sharpening problem-solving skills through the presentation of case studies that integrate scientific and clinical information is a necessity because the practice of medicine is an exercise in problem-solving. Wood observes that these requirements will change admission policies at medical schools; more of a premium would be placed on intellectual flexibility and the personality characteristics that lead people to choose primary care medicine as a career.

To put his plan into effect ,Wood and his faculty would work very closely with a few hospitals, create initially a special track within the COM for students who were interested in this approach, and probably place full-time faculty within the hospitals to provide the educational experience. Outside funding would be necessary; four major foundations have indicated an interest in supporting this approach.

What agency would certify the D.O. primary care specialist? Wood agrees that this is a stumbling block. While he would like to see a new osteopathic certifying board created, he is not optimistic that that will occur. It is more likely, he believes, that these graduates would be eligible to sit for the osteopathic boards in family medicine, internal medicine, or pediatrics or for an expanded general practice board examination.

Another unsolved problem is when to grant the D.O. degree, because of the implications for licensure and reimbursement. Traditionally, interns and residents have their D.O. degrees and are either eligible for licensure or in the process of being licensed, a status that allows them to treat patients and allows hospitals to charge for services performed by physicians in training, often a source of significant revenues for hospitals. Wood observes that it may be necessary to award the D.O. degree at the three- or three-and-a-half-year point in the process so that physicians in training may be licensed and legally entitled to perform treatment services and hospitals will be able to continue charging for their services.

OF INTEREST

In the next thirty days, look for

- the Senate Committee on Health Policy to report out Senate Concurrent Resolution (SCR) 395, which asks Congress to exempt the state's Department of Public Health from the federal tax on vaccines, and SB 501, which authorizes local registrars to issue copies of fetal death certificates for research purposes;
- the House Committee on Public Health to report out HB 5152 (utilization review), HBs 5217–20 (health care information), HBs 5272–74 (universal health benefits claim form), HBs 5268–70 (bone marrow transplant program), HBs 5180–82 (trauma systems), HB 4832 (medical waste), HB 5221 (hospital closure), HB 5250 (health facilities licensure), and HB 4643 (autopsy costs); and
- two bills giving patients access to information on providers to be introduced.

—Frances L. Faverman, Editor