Frances L. Faverman and Peter Pratt, *Editors*
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HEALTH POLICY BULLETIN

FOCUS: POWERS THAT BE—THE PUBLIC HEALTH COMMITTEE

Under the shared leadership agreement, Representatives Michael Bennane (D-Detroit) and John Jamian (R-Bloomfield Hills) co-chair the House Committee on Public Health. Although they have some significant philosophical differences, they probably agree more than they disagree. This article reflects our recent interviews with them.

Concerning health care reform, Bennane thinks the federal activity is acting as a spur to Michigan to devise a state-level plan. He is working on a plan he thinks the feds will allow the state to use that would entail community rating, uniform claim forms and data collection, and utilization review. The plan also would involve creating a State Health Commission and dividing the state into five regions, each of which would be governed by a board that would buy insurance for that region. Organizations such as Blue Cross and Blue Shield of Michigan, Henry Ford Health System, and Detroit Medical Center could offer the plan in southeastern Michigan.

Key ingredients in the plan are global budgeting and managed competition as well as the inclusion of workers' compensation, self-insured (ERISA) plans, no-fault auto insurance benefits, and Medicaid coverages. Big business would pay a 7-percent payroll tax. Flexibility in coverage would be preserved by allowing the purchase of additional options. In Bennane's view, the major advantage to the plan is that "it increases the preventive care available. Doctors won't avoid areas, because everybody would have insurance."

Jamian approaches health care reform somewhat differently. He wants "to make sure Washington gives us the funds, not mandates. The local system should fit into the national framework so that the uniqueness of Michigan is respected. I am especially concerned about health care delivery, particularly in urban centers." inadequate care for children is a major issue for him. "Primary care doctors must be available," he said. Jamian notes that national health care reform is expensive but it is a priority. His biggest concern is that we do not "rush into it and undo what we have done over a hundred years. We need to have checks and balances and to salvage the good parts of the system." In his view, "Realistically, if we have it [health care reform] in two years, that would be great."

Bennane and Jamian see eye to eye on global budgeting and managed competition. Jamian, however, has some concerns about managed competition: "What is competition?" he wondered. "What happens with a Henry Ford Health System? How do small providers survive?" He observed that in Lansing, for example, "Sparrow and one entity would do all the health care."

Where do they disagree? Bennane thinks that a state plan would work, and he is proposing such a plan. Jamian says "the mission of the legislature is not to design a plan—rather, it is to shape and implement a plan so that both patients and providers are satisfied." He thinks Michigan has already taken the lead in helping to deal with costs through initiatives to change the medical liability system, discipline and license health professionals, expand Medicaid, and deliver Medicaid services more economically.

In the end, though, Bennane may have articulated the perceptions of the majority of Americans when he said, "I think health care in this country is driven by the fact that every last one of us will pay whatever is necessary to be healthy. The health care community has taken advantage of that fact. We need to change the equation and bring some rationality to the process."

FOCUS: WOMEN'S HEALTH CARE

Congressman Bob Carr (D-8th District) and Kate Carr hosted a well-attended conference on women's health care issues on Saturday, April 17, at the Breslin Center on the Michigan State University (MSU) campus in East Lansing. Carr noted that General Accounting Office reports show that women were not included in several major studies. For Carr, the event that crystallized opinion was the famous study showing that an aspirin a day can keep strokes away—a study that included 20,000 men and no women. According to him, the study was easily understood by the public and got everyone's attention, thus highlighting the exclusion of women from major studies designed to test the effectiveness of therapies for conditions that affect both genders.

Vivian Pinn, M.D., director of the Office of Research on Women's Health, National Institutes of Health, was the keynote speaker. Dr. Pinn, a renal pathologist, is the first full-time director of the office. "The first problem," she said, "is to redefine what is meant by *women's health.* For too long, women's health has meant their reproductive health. We need to think of it as cutting across traditional

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

scientific boundaries." In a blizzard of statistics, she noted that women outnumber men in nursing homes 3 to 1; that in 1990, almost one-third of the seven million women over age 75 had some fairly severe limits on their activities; that 365,625 women die of heart disease each year, 232,815 die of cancer, and 88,200 die from strokes.

Pinn commented wryly that too many women worry about heart disease in their husbands, sons, fathers, and lovers but do not realize that it affects them as well. All the research on cardiovascular disease, she said, has been done on men. There are gender-specific issues for the history of disease in women, the aging process, responses to therapy, and the progress of disease, she observed.

Again and again, respondents to the address sounded the theme that access to health care meant more than getting into a doctor's office—that cultural, racial, ethnic, economic, and geographical diversity and barriers were important in the assessment of women's health care issues. It is not enough to be able to get into the system: The system must become more responsive to women and their special needs.

Marie Swanson, Ph.D., professor of medicine and director of the Cancer Center, Human Health Programs, MSU, noted that diversity also means the differences between rural and urban women and among various age groups. She cited breast cancer in younger women as an example of the statistical biases women also face: "Although women age 20–29 who have breast cancer will die at twice the rate for all other age groups, they are not included in studies because they account for only 10 percent of all cases." Age bias also extends to older women—least likely to be offered breast-conserving therapy are women age 65 and over, the group most likely to get breast cancer.

Marilyn Rothert, Ph.D., associate dean of nursing, MSU, spoke about decision making. The evidence is clear, she explained, that women want to become sufficiently informed so as to be able to make decisions about their health care. However, she pointed out, it is equally clear that providers want to persuade women rather than share decision making with them. One study she cited showed women about evenly divided between preferring a provider-patient 50–50 decision-making model and a model that allowed the woman to make decisions but had provider input. Rothert's presentation demonstrated that, when it comes to decision making in a health care context, women are not treated the same as men.

Raj Wiener, former director of the Michigan Department of Public Health (MDPH) and now an attorney specializing in health care and environmental issues, spoke about the system and the factors that are driving change. Wiener said, "We will live with the system a long time so we had better have an impact." She considers two questions to be critical: Will the changing system be better or worse for women? and Will the system be consistent with our vision of ourselves as a moral and just society? She noted that costs and the desire to contain them, not the inequities toward women and children, were the forces driving change in the system.

Vernice Davis Anthony, MDPH director, stressed three major areas in state planning for the 1990s: expansion of the programs to diagnose breast and cervical cancer in women, expansion of the services available to substance-abusing women, and expansion of family-planning services. She noted that family-planning services are the entry point to basic health services for low-income women.

Besides access to care, defining women's health care needs, and discussing the agenda for the 1990s, the conference also devoted some time to the need to advance the careers of women in the biosciences and biomedical sciences. Dr. Pinn noted that she was the only woman in her class at the Medical College of Virginia in 1961. She presented some telling statistics: Only one medical school in the country has a woman dean, only 13 women are department chairs, and women's salaries are well below those of men in the same positions.

Judging from the enthusiastic reception the speakers received, the conference was very successful. This observer, however, could not help wondering if the speakers were not preaching to the converted. Representatives of various women's groups and health professional groups were present. Conspicuous by their absence, with one notable exception, were the men who run the health care programs and who determine and define access to health care for women and children. It was also interesting to note what was *not* discussed—one woman physician noted that there was no discussion of the effect Alzheimer's disease has on women. In addition, abortion as a women's health care issue and self-insured plans and how their limitations affect women were not discussed.

OF INTEREST

In the next 30 days look for the following:

- the Senate to reconsider HB 4156, the auto insurance bill, which was passed in the Senate without immediate effect—a vote on reconsidering immediate effect is scheduled for May 4;
- the House substitute for SB 270 (the Matthieu-Nye version) to be resubstituted with a version drafted by Reps. Bandstra and Griffin; and
- the Senate to delay action on the licensure and discipline package while it waits to see what happens to SB 270 in the House.