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September 1993

HEALTH POLICY BULLETIN

FOCUS: AN INTERVIEW WITH DENNIS SCHORNACK

With President Clinton's health care reform proposal nearing formal and full disclosure in the next few weeks, we thought that it would be valuable to discuss health care reform in Michigan with Governor Engler's Senior Policy Advisor Dennis L. Schornack. Very shortly, Schornack will head a new office on health care in the executive office.

While acknowledging that school finance and property tax reform will occupy most of the governor's time for the remainder of 1993, Schornack said that Engler will push health care reform in 1994. "We want to see if there are changes we can make at the state level that move us in the direction of comprehensive reform," he said. "We must focus on what is affordable and achievable in the next year." Among ideas that he will consider for containing costs is the possibility of limiting teachers' health insurance costs: "We know that we can save a great deal of money if we competitively bid teachers' health care coverage," he observed.

Schornack also is excited about the cost-controlling possibilities of advances in information technology. He explained,

> We can build a climate to improve access and reduce costs through telemedicine. If a nurse in Marquette and an ophthalmologist at the Kresge Eye Institute in Ann Arbor were connected by fiber optic cable and two-way interactive video, the nurse could do all that is necessary for the ophthalmologist to diagnose and prescribe the proper course of treatment for the patient in the Upper Peninsula.

Lamenting the extraordinary administrative costs of our health care system, he noted that he also wants to move toward a paperless environment. "In 1968," he said, "there were 3.16 patients for every hospital administrator; today there are 1.43 administrators for every patient. This exemplifies an enormous cost problem."

Schornack is cautious when asked about the role the new office will play in health care reform in Michigan, saying

> I can't promise that the state will move forward with its own version of national reform and guarantee universal coverage with comprehensive benefits for everybody. States are in a unique position—they can move more quickly than the federal government, but they must balance their budgets. Whatever we consider, we'll cost it out carefully. The states that charged out in front on reform are now finding themselves on the "bleeding edge" instead of the leading edge. They now see that they will have to raise taxes or reduce the benefits they've promised their citizens. Some states have repealed tax support for their plans, while others have removed it from their agenda.

The new office will look closely at the reform plan when it arrives from Washington. "We'll determine what it means for Michigan, advise our Congressional delegation, and decide whether it's in our interest to support or oppose it," he noted, allowing for the possibility that the governor could oppose the overall plan and yet support certain aspects of it.

State legislative health care reform proposals by Representatives Hollister, Bennane, and Jamian also will be examined. "Representative Bennane is endeavoring mightily to piece together a plan that follows the Clinton framework, at least what can be put together from the press leaks. So far I haven't seen anything in his plan that's really workable," Schornack commented. He prefers the process set up by Rep. John Jamian. He said,

> Rep. Jamian is on the right track. He is trying to do what is achievable and he is doing that in an open and public process. We'll work with him in the sense that he'll be sharing with us the ideas that emerge from his process and we intend to share with him the ideas we have.

In fact, Schornack has been working closely with an advisory group of executive agency leaders for several months on health care reform. Jerry Miller (Department of Social Services), Jim Haveman (Department of Mental Health), Vernice Davis Anthony (Department of Public Health), Mark Murray (Department of Management and Budget), and Diane Braunstein (Office of Services to the Aging) have submitted a variety of analyses and proposals for reform that Schornack is reviewing.

He commented, "They are sort of my board of directors. Certainly, divergent perspectives are represented. In time, we want to focus on the two or three things each of us thinks are so significant that the state can take unilateral action and achieve real change in affordability, access, and quality."

The prospect of reform has forced states to reassess their role in paying for health care. Schornack said,

> Defining the state's role is key. It is one thing to say that the state will make every effort possible

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> to make health care accessible and affordable and ensure quality; it is quite another thing to say that the state will provide coverage to every citizen. The state may decide to step in only with people without any connection to the work force who are poor, in partnership with the federal government.

Schornack is interested in looking at having Medicaid cover all people at or below 100 percent of poverty, regardless of whether they are categorically eligible. "A lot of people are poor but are categorically ineligible. It would be nice to move away from categorical eligibility. It will take waivers from Washington, but it might make good sense," he added.

Asked for his priority in health care, Schornack answered directly: "Getting more health for the health care dollar." He would like to "improve performance and reduce redundant costs while preserving to the greatest extent practicable individuals' choice and the excellence of technology." Schornack is keen on the virtues of technological progress. "No society should ever turn its back on technological development in any field of endeavor. We've seen some tremendous technological advances that have dramatically reduced health care costs and the need for expensive inpatient hospital care," he commented.

On improving performance, Schornack believes that most competition in health care is now based on price, not quality. "Quality is the biggest challenge out there," he added. "Everyone will tell you we have basically high quality health care, but no one can tell you how to measure it yet. We're going to look at it." He mentioned the value of patient satisfaction surveys. "Citizens ought to know that information," he stated.

Schornack sees a role for public health in measuring outcomes:

> Public health has gotten further from the basic tenets of public health—assuring a clean water supply, epidemiology, and others—and into the delivery of care. Reform may leave public health out of the luck with health care delivery. The challenge for public health is to redefine itself in the context of national reform. In my judgment, public health needs to return to its roots and expand into outcomes analysis.

Schornack says that his new office also will be wrestling with the difficult issue of health professions education: "Unfortunately, the market for physician labor is disconnected from the payers. If I am a hospital, a clinic, or an HMO [health maintenance organization] looking for primary care providers, the signals I send to the universities aren't getting through. The time lags are huge."

He quoted from a speech, given at the recent state HMO conference, in which Paul Ellwood suggests that health plans be taxed to pay for graduate medical education. In exchange, the health plans would take charge of setting the number of physicians that would be trained in primary care and other specialties. Schornack explained, "What he's getting at is that the market needs to connect with the universities. Now, the state and federal governments sweep up all this money from the taxpayer and send it off to the constitutionally independent universities, who then allocate it according to student demand. And, of course, most students want to be specialists."

There also is promise in physician extension, especially via technology, Schornack thinks. He noted,

> This is a very interesting area that I want to look at, as there are ways of extending the eyes and ears and knowledge of doctors to those who are very well equipped, such as nurses. We can vastly improve access by using our 45,000 nurses—many of whom are highly trained—better. Are we utilizing them to their fullest? I think it's arguable that we're not.

Schornack is clearly eager to build on the accomplishments achieved in health care in the recent year, noting that virtually all of the reforms that Governor Engler outlined in his special message on health care at Hutzel Hospital in March 1992 have been achieved (medical liability and certificate of need reform, expansion of Medicaid managed care, antismoking initiatives, health professional licensure and discipline reform, and expanded access for 82,000 children through the Healthy Kids initiative likely to be part of the FY 1994 Department of Social Services budget). With reform proposals coming at the executive office from many different angles, Schornack will have his work cut out for him.

OF INTEREST

In the next 30 days, look for

- the House Public Health Committee to make significant changes to HBs 4749–4752, the Health Care Information Act, and to take up HB 4962, which would add certified nurse midwives and certified nurse practitioners to the list of people qualified to provide HIV counseling to people applying for a marriage license
- the Senate Committee on Public Health to hold hearings on SBs 590–593, which would require preferred provider organizations and HMOs to notify health care providers before entering into selective contracting arrangements for prescription drugs and durable medical equipment and to take up HBs 4569–4573, which would provide reimbursement for chiropractors and optometrists.