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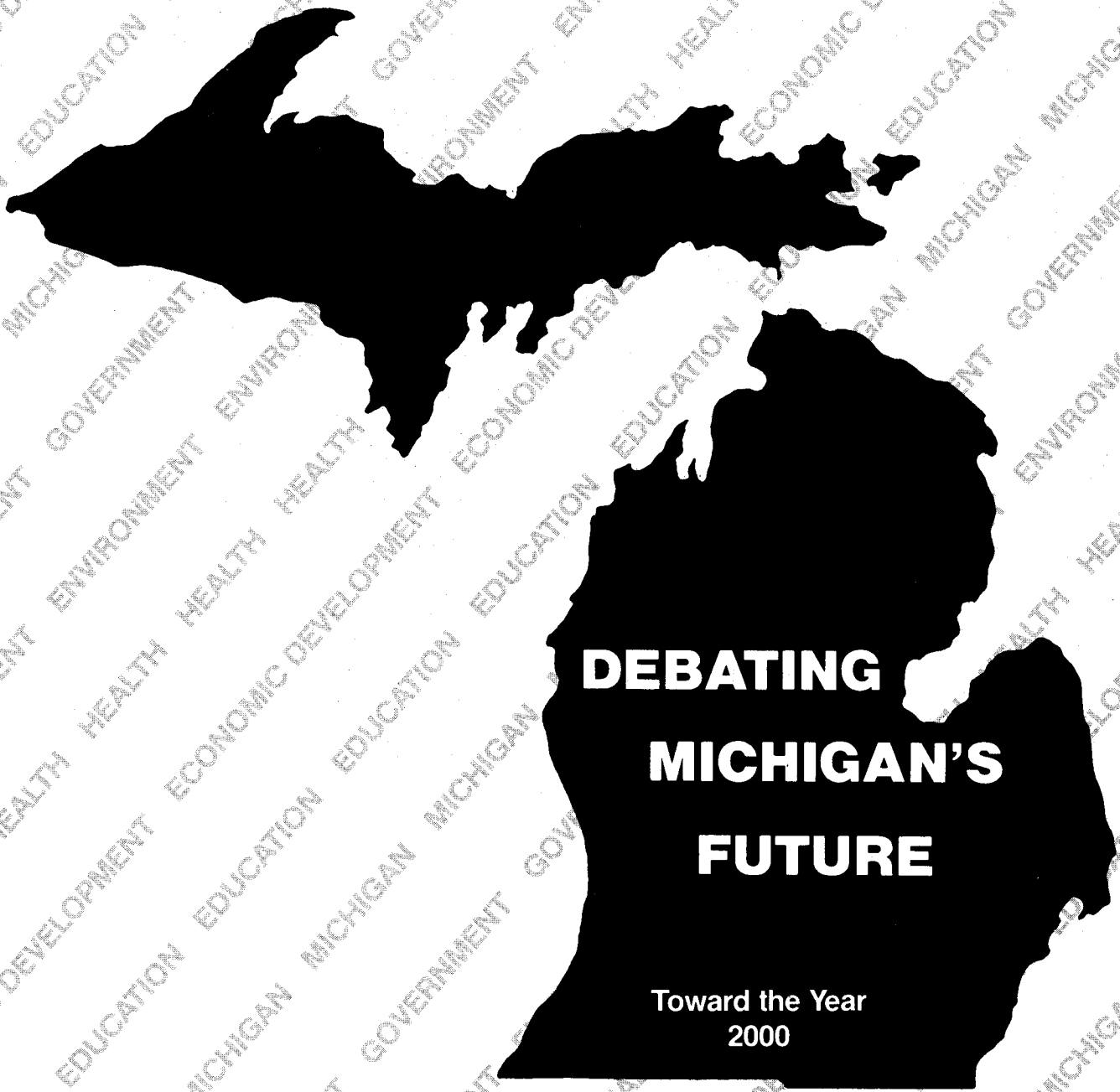

DEBATING MICHIGAN'S FUTURE

Toward the Year 2000

These papers are presented to encourage thought and discussion. The comments of our readership are welcome and may be incorporated into the final publication, a compendium of the series.

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V. HEALTH CARE IN MICHIGAN

The forces affecting future health care policy in Michigan will be shaped mainly by shifts in the age of the state's population and by the continuing struggle of both government and the private sector to constrain medical care spending without unduly limiting access to care.

Demographic Shifts

By about forty years from now, in 2030, one of every five Americans will be 65 years old or older. Between now and then, the 85-and-older population will increase three to four times as fast as the general population. From 1980 to 1995 alone, the nursing home population is expected to grow from 1.2 million to 1.9 million; by 2040, 4.3 million elderly (65 and older) are expected to be institutionalized.

Michigan's population is slightly younger than the national average. About 11 percent of our state's people are age 65 or older; by 2020, this group will comprise 16 percent.

The elderly have higher rates of illness, injury, and disability than does the general population; they need more medical services, and their medical care is more intensive and prolonged. People over 65 years old use hospitals three and one-half times more often than do those under 65, and they are likely to stay in the hospital longer.

The increase in the elderly population will stimulate demand for medical care in various specialities, increase the need for outpatient care, and necessitate training more professionals in geriatrics and gerontology--expertise already in short supply according to a recent report from the U.S. Department of Health and Human Services.

The aging of the population will also call for new and better ways to provide long-term care. Alternatives to institutional long-term care are needed to reduce dependence and unnecessary institutionalization. Demand will increase sharply for social support services, such as home health care, personal care, specialized transportation, mental health programs, and congregate housing.

Finally, while the aging of the population will increase the demand for medical care, there will be proportionally fewer younger and middle-aged people in the work force to support the costs of government and private insurance.

Costs and Reimbursement of Medical Care

In 1984, 10.7 percent of U.S. gross national product (GNP) was spent on

health. In other industrialized nations the figures were:

Sweden	9.4 percent	Netherlands	8.6 percent
West Germany	8.1	Canada	8.4
France	9.1	United Kingdom	5.9

In 1985, U.S. health care expenditures totaled about $425 billion, 10.6 percent of GNP. (In Michigan, an estimated $15-16 billion was spent in 1985.) By comparison, in 1960, national health care expenditures accounted for 5.3 percent of GNP. Thus, the most recent generation of Americans doubled the value placed on medical care relative to all other societal needs.

Where does the money go? Nationally, 39 percent of all health expenditures in 1985 were for hospital care; 19 percent for physicians' services; 8 percent for nursing home care; 8 percent for drugs; 6 percent for dentists' services; 6 percent for personal health needs; and 6 percent for administration. Public health activities consumed about 3 percent of all expenditures, construction of medical facilities about 2 percent, and research about 2 percent.

Where do the dollars come from? The federal government (primarily through the Medicare and Medicaid programs) pays 29 percent of the total health bill. State and local governments contribute 12 percent. Private health insurance pays 31 percent. Patients pay 25 percent directly. Philanthropy and other sources account for the remaining 3 percent.

Financing long-term care services has already become a critical concern of health planners and policy makers. At present, the principal means of financing long-term nursing care for most older adults is through Medicaid. As a result, in Michigan and many other states, Medicaid has been the fastest growing budget item over the past ten years. Alternatives for financing long-term care must be found. Likely arrangements include medical IRAs, long-term care insurance, wider use of home-equity conversion, and government-supported catastrophic health insurance programs.

Another area of concern to health policymakers is financing the health care for high-risk uninsured individuals, who number about 35 million nationwide. Legislation pending in Congress would require states to establish pools to provide comprehensive health care coverage for the uninsured. Some subsidization of medical expenses for the uninsureds is necessary; the major policy question will be who pays for the coverage--government and/or the private sector?

Improving Personal Health

Declining mortality has caused the world's population to expand. It took perhaps as many as one million years for the human population to reach one billion. The second billion was added in 100 years; the third in 30; the fourth in 15, and the fifth in 11. The modern rise in population resulted chiefly because better hygiene reduced infectious diseases; by the 20th century, immunization against and treatment of disease began to improve health significantly. The public became more confident in the ability of medical science to cure and prevent disease and more aware of the environmental and behavioral factors responsible for good health.

Because of its past success, medical science today plays a smaller role in good health and long life than one might imagine. According to Thomas McKeown, a Canadian health policy analyst, to be well, one must be born free of major congenital disease, be adequately fed and protected from hazards in the physical environment, and not smoke, overeat, or live a sedentary life. Today a person living in the United State has great influence on his or her state of health and, indeed, his or her life span. As medical science and technology chip away at morbidity (disease) and mortality rates, personal responsibility for good health continues to increase. One result of improved medical science is, frankly, its diminished consequentiality to good health. McKeown makes this point more bluntly:

> A moderate or heavy smoker would probably live longer by giving up smoking and giving up doctors than by retaining both.

John Knowles, a widely recognized authority in preventive health care, suggests that "the next major advances in the health of the American people will be determined by what the individual is willing to do for himself and society at large." Combined with progress in identifying disease earlier and in eliminating or reducing harmful environmental factors, behavioral changes such as reducing alcohol and cigarette use are expected to extend average life expectancy in the coming decades. Whereas a female born in Michigan in 1984 can expect to live 77 years, one born in the year 2000 may expect to live 90 years or longer.

Preventive health care is becoming increasingly important both as individuals seek to improve their life-styles and as organizations seek to improve productivity and reduce escalating costs of health care. The corporate sector is increasingly interested in weight control, stress management, health education, and other "wellness" activities for employees.

Because many chronic diseases have their origin early in life, wellness programs in schools can help ensure that good health habits start young and become a way of life. Michigan school districts are beginning to appreciate and expand their role in health education; the Michigan Department of Education's model for comprehensive school health education is being adopted widely. Hospitals, health maintenance organizations, and other providers are also emphasizing wellness and health education programs.

Modifying health-related behavior is very complex; more effort and resources must be focused on health education research and on bringing the benefits of health promotion to children, the elderly, and the poor. Both public and private insurance coverage should be extended to cover a well-defined package of basic preventive services. Premium rates should reward efforts to stay well. Unfortunately, the current health care reimbursement system does little to encourage--and indeed may discourage--individuals from assuming more responsibility for their own health.

The Health Care Delivery System

During the 1950s and 1960s, government fostered the growth of medical care services in many ways. Hill-Burton construction dollars force-fed explosive increases in the number of hospitals and beds. Medicaid and

Medicare compensated providers for care they had previously given at no charge to the indigent and elderly and increased access by rich and poor alike to high quality medical care. After spending billions of dollars on building hospitals, enlarging medical schools, and expanding access to medical care, government concluded in the 1970s that providers were delivering too much service. Through certificate of need programs and Medicare and Medicaid policies, government began to regulate against the development of health care services it had, in fact, stimulated and funded.

Corporate America was not far behind government. The labor contracts of the 1960s and 1970s gave workers access to a wide array of health care services at little or no cost to employees. Then, in the 1980s, just as government tightened the purse strings, corporate America decided the medical care industry was getting too rich at its expense.

The decision by government and business to limit spending on health care has left the health care system with an excess of beds, services, and personnel. The result is more competition for existing health care dollars. The combination of spending limits and increased competition has introduced traditional business principles into the operation of health care facilities, producing a marketplace that rewards efficiency.

In the 1990s, competition will lead to a shrinking and consolidation of the nation's health care delivery system. There will be fewer beds and hospitals, particularly community hospitals; fewer medical and dental schools and students; fewer interns and residents; and fewer large medical centers. There will be more chains of health provider corporations (profit and nonprofit); more care extenders, such as physicians' assistants, nurses, home health and hospital care services; and more outpatient services. It is quite possible that by the year 2000 Michigan will have five or fewer corporate medical systems, each with a flagship hospital fed by regional hospitals, which are fed in turn by smaller satellite facilities. Each system will own and operate long-term care, hospice, home health, and all other similar services. The problem is that the pendulum may shift too far toward constriction; the result then would be a rationing of care brought about by the undersupply and higher prices of services.

Consumers' choices of hospitals, physicians, and medical procedures will narrow. As options are reduced, consumers will have less access to personal medical care as they know it today. "Routine" health care and education will be handled largely by paraprofessionals, such as nurse practitioners, physicians' assistants, and nutritionists.

Not only will free choice of providers be a privilege of wealth, but also the "dual system of care--one for the rich and one for the poor" will become more entrenched. Hospitals and nursing homes offering care exclusively to private payers may be established; these facilities may cater as well to foreign patients, proving that health care, like auto manufacturing, can be an international industry.

Michigan's Policy Options

Michigan is spending more than one-half billion dollars per year on Medicaid, yet must defer to the federal government in determining who shall be eligible and what health care services they shall receive. State regulatory functions, such as licensing health care professionals and approving or

disapproving facility plans for capital expenditures, have not been particularly effective in guaranteeing quality or constraining costs. The Michigan public mental health system is beset by clinical, quality of care, and civil rights problems and has been relinquishing to the private sector a greater share of institutional care. State environmental health policies and regulations are set and administered by so many different departments and agencies that coherence is difficult to achieve. In addition, environmental health is rapidly becoming not so much a state as a national and, indeed, international issue.

It is far from clear that state government will enjoy any lasting role in making health care policy. By the year 2000, we envision state governments withdrawing from such activities as:

- financing health care for the indigent (Medicaid)
- arbitrating what health care services facilities will provide (certificate of need)
- operating health care institutions (the public mental health system)
- setting environmental standards

In financing health care, state government will increasingly be faced with the medical bills of the indigent and underinsured. In the past, to provide free or nearly free care to the poor, providers were able to overcharge the paying customers. As insurers and employers clamp down on medical care spending, hospitals, physicians, and other providers will be increasingly unable to provide care to the indigent without reimbursement.

The challenge of assuring access to health care for the needy will be dropped on the doorstep of the U.S. Capitol because no state can afford it. Certainly, within ten years there will be a national policy and reimbursement fund for medical care to the needy, or at the very least a national catastrophic fund to protect life savings of the aging from evaporating during a single illness. It is likely that Medicare and Medicaid will be merged into one program of reimbursement for those without financial means to pay for medical care; we foresee little likelihood that state and local governments can afford to participate in the combined program. Uncompensated care will be a major problem for hospitals until such a national strategy is implemented; uncompensated care in Michigan alone cost hospitals $214 million in 1984. As a trade-off for the federal government picking up Medicaid and uncompensated health care costs, the states may become more fully responsible for financing and operating other social welfare programs, such as income support and clothing, shelter, and food allowances.

The certificate of need program, designed to limit capital expenditures to projects and services with demonstrated need, has been largely ineffective --not just in Michigan but throughout the nation. The program fails to restrain the vast majority of projects; it restricts competition--one consequence of which is artificial protection of inefficient health care institutions; it delays unnecessarily the introduction of labor-saving technologies; and it retards the integration of services into broad health care corporate systems. In this era, when public and private insurance reimbursement for costs is based on competitive prices, the best determinant of need for capital expenditure is the marketplace, not the government.

In the face of the inevitable consolidation of the health care system, state governments must plan to minimize the economic and social pain of

dislocation and closure of care facilities. For example, Michigan must examine alternative uses for excess capacity in hospitals, one being long-term care facilities for the increasing older population.

The number of people institutionalized in Michigan's public mental health system has dropped dramatically. At the end of fiscal year 1959-60, more than 30,000 individuals were being cared for in Michigan public psychiatric hospitals and centers for the developmentally disabled. Today, the number is about 5,500. The Michigan Department of Mental Health now contracts with private hospitals and care-givers for much of the direct care that its patients historically received from the state. As the private sector is encouraged to expand psychiatric care for children, adolescents, and adults, it is possible that within a decade Michigan will close the doors of all or nearly all its mental health institutions.

As the world shrinks and environmental issues take on global significance, standards for air and water quality, worker health, and similar environmental health factors will be set by national and international bodies. States will defer more to the federal government for review and establishment of environmental standards, which in turn will seek the assistance of international bodies in assuring global uniformity on at least minimum standards. State governments trying to attract business will no longer need to lower environmental and health standards to be competitive.

While the role of state governments is decreasing in the areas noted above, they will increase in protecting and promoting individual health. We envision Michigan more actively

- promoting health, rather than regulating health care systems;
- policing, rather than setting, environmental and health standards; and
- overseeing outcomes of medical care, rather than merely licensing health occupations, professions, and institutions.

As the health care industry consolidates, public policy must center on improving access to and financing medical care for the elderly and the poor; the state's role will be subsumed by the federal government in this regard because of the expense. There are areas, however, in which the state can effectively serve its citizens. By reemphasizing traditional public health activities--promoting behavior changes, providing consumer and health education, and disseminating information about communicable diseases--state government can have a beneficial effect on the public's health. The most good can be accomplished, however, by overseeing professional competency and the results of medical care, rather than by merely issuing credentials to health providers and facilities.

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