

Three perspectives: The impact of public policy on the competitiveness of Maine's business and industry

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The twentieth anniversary of the Governor's Economic Development Conference last October focused on the impact of public policy on the competitiveness of Maine's business and industry. Among many other important presentations, the University of Maine-sponsored conference featured a televideo keynote address by the Clinton Administration's top economic advisor, Laura D'Andrea Tyson. Tyson's remarks, which detailed the Administration's policy initiatives meant to enhance the nation's competitiveness relative to the international economy, are presented in this issue of Maine Policy Review, along with two other presentations as representative of the quality of the discussion that occurred at the conference. UNUM Chief Executive Officer James F. Orr III cautioned conference attendees that, while President Clinton deserves credit for some of his early initiatives, the path to establishing a national economy that will position the U.S. for the next century is a long and difficult one. Finally, Warren C. Kessler, president of Kennebec Health Systems, assesses Clinton's health reform proposal.

Assessing the merits of the Clinton health care reform proposal

by Warren C. Kessler

Introduction

This era of debate over national health reform is an exciting and very promising time for Maine's health industry and for the people it serves, which is everybody in the state of Maine. President Clinton gets very high marks from our industry for framing and initiating the debate. He is the first President in about thirty or forty years to run on a platform of national health reform, and he has had the courage to stake his administration and, in many ways, his re-election on the passage of this legislation. This interesting bill offers great promise and serves as an excellent starting point. Clearly, the bill will be changed in the political process, but the result will look something like its initial form when it emerges from the legislative process, probably a year from now.

Three aspects of that bill are addressed here: universal entitlement, reliance on managed care, and reliance on cost caps.

Universal entitlement

There are four major groups left out of the Clinton health care reform bill. The first is Medicare, the most important group. Medicare patients, of course, will be insured, but not under the new national program. This exclusion is one of the biggest problems that I have with the Clinton bill. The Medicare population represents about twelve and a half percent of the nation's population and about thirteen and a half percent of Maine's population. But it also represents about forty percent of the population found in the nation's hospitals, and an even larger percentage of the

population in the nation's nursing homes and in most of its home care agencies. This population has an enormous impact on the cost of health care and leaving it out will present some major problems. The second group left out is the military. This exclusion is very understandable. The third group is the veterans. The last president to tackle the veterans Administration system was President Nixon, and that was almost as big a problem as Watergate. No one else has tackled the system since then, and apparently President Clinton will not make the attempt either. The fourth group left out of this bill are those who come under the jurisdiction of the Bureau of Indian Affairs. By far, however, the largest and most important group is Medicare.

Reliance on managed care concepts

This bill calls for, and most similar bills also call for, a fee-for-service option available for all Americans. I put almost no stock in that. Fee-for-service options will be inherently expensive, will be paid directly by the consumer, and will be potentially non-tax deductible expenses. These "options" are almost certainly not a real choice for the vast majority of Americans under any conceivable scenario. The rest of these bills are high- or low-deductible bills built around the concept of managed care and particularly the concepts of capitation - that is, a uniform per capita fee system. This is an extremely progressive way to view our national health care payment system and should lead to some very good things indeed if pursued to its ultimate conclusion.

Managed care is not a new concept. Although many of us are worried about the new things in the Clinton bill, we do not need to worry about managed care. We have seen it work and not work in many other parts of this country. For example, California's private insurance industry is dominated by managed care concepts.

The incentives in the current fee-for-service system are clearly to provide more health care services. The health care industry has been doing more for decades, both *with* and *to* the American public. This is almost inevitable, and we are joined in this by all the other Western developed nations, which are doing more and more and more for rapidly aging publics. Not surprisingly, the aging population requires more care. Technology has allowed us to do more, and so far the American public has supported health care providers doing more. But this is causing some other problems for this country which I will address under the cost caps.

In contrast to the present system, the incentives in managed care are predominantly to do less. There is some danger in doing more, just as there is some danger in doing less. They both need to be watched very carefully. The Clinton bill, to its credit, places a significant emphasis on quality control and quality reporting to the American public. But the incentives in managed care are to do less. Under managed care, there will be far fewer hospital beds and hospitalized patients in this country. There will be less busy medical specialists, and there will be a greatly increased demand on primary care, a demand that I am concerned about our ability to meet in the foreseeable future. Those are clearly the incentives.

The Clinton bill includes some negatives for hospitals in Maine as well as the rest of the nation. The hospital system in this country was established and sized through the Hill-Burton Program, which was in place in the late forties through the mid-seventies. Hill-Burton used a formulaic approach to hospital size that called for four beds per thousand population. That is an interesting

number. I happen to know where the number came from. A professor of mine, who was one of the original drafters of the social security law in this country, was giving testimony to a Congressional committee on the Hill-Burton bill back in the forties when someone asked him how much hospital care there ought to be available. The professor responded that he did not know, but would return the next day with an answer. After that, he started calling his colleagues and found somebody in Maryland who said, "We've been using four beds per thousand in Maryland and it seems to work." My professor promptly gave that information to the committee chairman, Wilbur Mills. As a result, the magic number of four beds per thousand became the standard for the next forty years. Maine, fortunately, has slightly less than four beds per thousand (3.7). But even that number will be woefully large in relation to the need for hospitalization under managed care. Managed care will cut the use of hospitals, primarily by cutting the length of stay, to somewhere between one and two beds per thousand. That represents a lot of adjustment on the part of this state's hospitals. We will see more efforts like the one now underway in Greater Portland. There, a very forward-looking proposal has been made to consolidate the three major hospitals into one system and then to downsize that system. This effort reflects the problem arising from the availability of 950 hospital beds in Portland, when the projected need is only 650.

So, the state's hospitals will be downsized to some extent under universal health care if the Clinton bill is adopted. That does not touch outpatient care, which is a significant proportion of our business, and it may or may not touch the Medicare population. If Medicare is excluded from this system, hospitals will be in the unenviable position of having great incentives to moderate the services they provide to sixty percent of the population, while continuing to provide more and more services to forty percent of the population. Because Medicare is paid on a per-admission basis, there is a clear incentive for more admissions. Medicare pays physicians on a fee-for-service basis, so there is clearly incentive for physicians to do more. If Medicare is out of the system, then there clearly will be two sets of incentives: the incentive for older people is to do more, and the incentive for the under 65 population is to do less. I am not sure how any hospital can respond in an appropriate way to those incentives. If the state of Maine has an option (and it may have an option to include the aged population in a plan through some kind of Medicare waiver and perhaps a capitation system for Medicare), then I would urge the state to seriously consider aligning its health care incentives in one direction.

The second part of managed care is a reliance on primary care. Maine has almost no experience with managed care. A year ago, we had less than three percent of our population under managed care concepts. Today, Augusta, primarily because of Blue Cross, has nearly thirty percent of its insured population under managed care incentives. That has put enormous strain on our primary care system. I am deeply concerned about our ability as a nation to create enough primary care physicians quickly enough to successfully implement the managed care concepts for all Americans by 1997. In Maine, there are four or five areas that do primary post-graduate medical education. Bangor has a family practice residency at Eastern Maine Medical Center. Augusta has a family practice residency program that it manages in cooperation with Mid Maine Medical Center in Waterville. Central Maine Medical Center has a family practice residency program, and three of the Portland hospitals are involved in primary care post-graduate medical education. Those programs must be expanded as rapidly as possible. As a second goal, Maine must pay particular attention to efforts to enhance its primary care physician supply, because all

Americans will go through their primary care physician to get services anywhere else in the system. This is an appropriate use of primary care physicians, and an appropriate way of moderating the forces of expansion in health care. But this objective will be very hard to accomplish unless there are many more family physicians or unless we expand the definition of primary provider.

Lastly, we will have some specialists who will be less and less busy. That has been true in California. We may see the beginning of actual unemployment on the part of physician specialists. This, of course, means that we will have to be very careful about the kinds of specialists we include in the physician population. These specialists will become a cost center, as opposed to an income center, in a health care system that operates on a capitated basis. There, by the way, is no evidence that the incentive to do less is damaging to patients. We in health care like to say that if we have incentive to do less, then we will be inappropriately short-changing the American public. A lot of research has been done, and there is no evidence that, in places where managed care has been implemented, the health of the population has suffered. Indeed, there is some evidence, although very small (we do not know a lot about outcomes in this business) that doing too little is better than doing too much.

Cost care caps

Virtually all providers are concerned that the Clinton bill will slow the rate of increase in health care costs to the rate of inflation plus population growth by the year 2000. The American Medical Association will lobby against these provisions. The American Hospital Association will lobby against some of them, but probably not too loudly. The problem is this: Currently, the United States spends approximately 14.8 percent of its gross national product on health care. Under Clinton's plan, that will rise in the next seven years to approximately seventeen percent of the gross national product. That percent would level off then and behave as a function of inflation and population growth. It is inconceivable that the health care industry could make a case that one out of every six dollars spent in the United States is somehow not enough to provide health care for the population of the United States. This is one of the key elements of the debate. If we do not halt the escalation of health care expenditures, we will undermine the economic base that supports health care.

I happen to be an advocate for health care, and I do not want that economic base eroded. We clearly must face this problem. This nation cannot afford to use ever-increasing percentages of its wealth and its resources in one area of its economy, health care. There are other needs such as education, housing, defense, and food that demand equal attention. I am deeply concerned that if we do nothing about increasing health care costs, the percentage of gross national product devoted to health care will rise to a level that would make doing business in this country totally incompatible with functioning in a competitive, international economy.

Conclusion

As we observe and engage in the health care reform debate in the coming twelve months or so, we here in Maine should plan our own health care system. It is not too early to begin the partnership between government and business and, hopefully, health care providers and insurers,

and to discuss and to debate the kind of system that we want for this state. We do not know all that will come forward from Congress. We do not even know yet that *anything* will emerge from Congress. I believe, something must come forward in the immediate future or we will have a very difficult time developing and making well again our national and state economies.

Warren C. Kessler serves as president and chief executive officer of both the Kennebec Health System and the Kennebec Valley Medical Center in Augusta.

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