

Commentaries on the Maine Health Care Reform Commission

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The final report of the Maine Health Care Reform Commission (MHCRC) was submitted to Governor King in November, 1995. Given the complexity of what we call the healthcare system as well as the moving targets of federal and state incentives for reform, the report accomplished a great deal in a short period of time.

Commission members were "mandated to offer a single payer universal coverage bill, a multiple payer universal coverage bill, and a bill to achieve reform through incremental changes to the existing system, emphasizing cost containment, managed care, and improved access. The commission was also mandated to cost out its recommendations" (Executive Summary, MHCRC Report).

Reactions to the MHCRC report were invited from individuals who represent constituencies which often have an influential role in healthcare. Five commentaries address pros and cons of particular elements of the commission's report: the first is by David Wihry, an economist at the University of Maine; the second comes from Peter Millard, Clifford Rosen, and Susan Thomas, practicing physicians in Maine; Representative Richard Campbell (r) comments on the development, process, and outcomes of the commission; Elizabeth O. Shorr, Blue Cross and Blue Shield, provides a third-party payer perspective; and Dale Gordon and Kim Boothby-Ballentyne offer a nursing perspective. Adjunct to these commentaries, Senator Dale McCormick comments on the work of the Maine Health Professions Regulation Project and links the efforts of this task force to that of the commission's recommendation to adopt an incremental reform plan in Maine.

Response to Draft Recommendations for Health System Reform

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Faced with issues of rising healthcare costs and decreased access to affordable healthcare and insurance, the 1994 Maine legislature established the Maine Health Care Reform Commission. The task of the commission was to draft recommendations for healthcare system reform. The following response to those recommendations reflects the perspective of two nursing educators who also are employed as nurse practitioners in advanced practice.

A major concern with the report and recommendations is the lack of interdisciplinary collaboration in the entire process. The commission included a physician, but surprisingly no nurses, even though nurses comprise the majority of healthcare providers in Maine today. Nurses pioneered public health and remain at the forefront of health promotion and prevention, yet the entire report is remarkable in its failure to acknowledge the role of nurses in healthcare reform.

This oversight would have been avoided by including representatives from nursing on the commission. The commission composition is significant in that it affected the focus and tone of the entire report. For example, the report recommends the capping of attorney's income in malpractice cases, but fails to address that physician salaries are much higher than other professionals with equal education and training. The report emphasizes the interests of providers--both physicians and hospitals--by identifying ways that bills may be paid while continuing to engage in "business as usual." The interests of the consumer for more appropriate care are secondary. The emphasis remains on medical care with a brief acknowledgment that public health expenditures should be increased from one to approximately three percent of healthcare costs.

Given that the majority of Mainers suffer from health problems directly related to poor lifestyle decisions, and not infectious disease, the emphasis on medical care and treatment seems inappropriate. Furthermore, with movement toward managed care, there is a shift of incentives for primary care providers to keep patients out of acute care settings versus admitting them for long hospital stays. Perhaps a new concern is not the over utilization of healthcare services, but the under- utilization of those types of services which ultimately will decrease the need for care.

The report presents three payment models with a stated preference for incremental reform. The single payer model works well for Canada. In spite of complaints about delays in obtaining care, the vast majority of Canadians consistently state a preference for their healthcare system over what is available in the United States. Healthcare costs consume about twice as much of the gross national product (GNP) in the U.S. compared to Canada. No one has proof that healthcare in the U.S. is twice as good. From a consumer and provider perspective, the simplicity of the Canadian plan is remarkably appealing.

Unfortunately, the commission report states that implementation of this single payer plan is not feasible because of its associated astronomical tax increase. Given savings in health insurance premiums, out-of-pocket payments, single payer billing/reduced bureaucracy, and savings from preventive care and health promotion, what is the actual cost of that plan to the consumer? Although healthcare is currently financed by a mix of public and private payers, the original sources of funds are the consumers, workers, and tax payers, with the dollars merely taking different routes to the providers. Whether directly visible or not, ultimately we all pay under any plan. What is the true cost difference to consumers under this one?

The multiple payer plan has the advantage of appeasing the interests of scores of health insurance companies. It also carries with it copayments and deductibles which have long been a source of controversy. Although these copayments are designed to encourage the judicious use of healthcare and act as a deterrent to unnecessary utilization, most consumers are unable to assess "judicious use" as a lay person. Indeed, that is why they seek a professional assessment of their illness and its severity in the first place. Also, deductibles adversely impact low income individuals and decrease the utilization of preventive services. In those three circumstances, deductibles merely serve as a barrier to obtaining care.

The incremental plan allows Mainers to keep the best of the worst and adds yet another layer of bureaucracy, an alliance. The alliance will allow consumers and businesses to control the administration and purchasing of healthcare. The report notes that to avoid conflict of interest, no providers will be part of the alliance. This assumes, perhaps incorrectly, that consumers and businesses have the health knowledge needed to make purchasing decisions about a complex commodity. The decisions may be governed by the economic best interests of the employer. Furthermore, the plan implies the alliance will have choices of healthcare plans and providers, when current trends of mergers and consolidations suggest monopolies may evolve.

The standard benefit package includes a curious though comprehensive assortment of benefits ranging from podiatry to Christian Science care. The portion of the package that is nursing is unclear. The financial coverage of catastrophic illness such as traumatic brain injury and bone marrow transplants is also unclear. Will those options only be available to wealthy individuals who pay out-of-pocket?

What role will nursing play in managed care? In public health? Will the plan increase the utilization of nurses in advanced practice because they are more cost effective in providing primary care? Research indicates that 85 percent of primary care needs can be met by nurse practitioners and that nurse practitioners provide a higher quality of care in many circumstances. Given that the new LD 948 recognizes nurses in advanced practice as independent practitioners, why were they not mentioned in this healthcare reform? They are an untapped resource with the ability to provide cost-effective care, emphasize health promotion and illness prevention, and improve access to care in poor rural areas of Maine. There are now three graduate level nurse practitioner programs in Maine. Half of last year's class from the University of Maine were from Aroostook county and returned to that rural area to practice. Funding the education of several nurse practitioners is less expensive than recruiting and establishing one physician in a rural practice.

A quality assurance program that examines the appropriate processes of care and patient outcomes is a wonderful concept. Unfortunately there is a lack of outcome-based research and data. Nursing and other professions have been attempting to gather outcome-based data for years. Outcome-based research is in its infancy. Where are the studies and research data that show the interventions are effective? Where are the globally focused data collection systems that will examine inpatient-outpatient-community-health promotion outcomes? What outcomes will be valued? Quality of life? Mortality? Patient satisfaction? Return to work and social productivity? Minimal consumption of healthcare monies? Who will decide?

Furthermore, how will quality assurance be implemented? Will there be peer review? Medical records review? Case audits? What will be in place initially before the research results on outcomes are known? A report card on a payment plan is a good idea, but most patients would prefer a report card on provider outcomes and competencies. What if, once desirable outcomes and competencies are identified, a provider receives a poor continuous quality improvement profile, and fails to change his/her practice? What recourse exists? What if a provider opts out of the plan as providers have done for Medicaid?

The need for a comprehensive health data system in Maine is indisputable. The value of data collection is clearly presented in this report. Unfortunately there is little understanding of the cost of such data collection, analysis and compilation. For example, physician manpower data has been collected for years using federal monies. Nursing is not eligible for those monies. During the latest nursing shortage the Commission on Nursing Supply and Educational Accessibility in conjunction with the Maine State Board of Nursing recognized the need for collecting basic data about Maine RNs and LPNs. This one-time data collection surveyed active and inactive nurses, practice location, and work setting, had a price tag of over \$125,000 in 1990, and took two years to complete. How will such data collection be funded?

As nurses we strongly believe in universal coverage with a standard benefits package and support any federal legislative action towards that end. The report clearly identifies federal barriers to the implementation of any of these proposals. The issue, then, is how to proceed while awaiting federal reform. Unfortunately the Maine Health Care Reform Commission's recommendations create as many questions as they attempt to answer.



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