On the Road to Revolution: Fear and Loathing in the U.S. Health Care System

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Last summer as Hurricane Katrina pounded the Gulf Coast, the levies along the Mississippi River broke sending massive flood waters into New Orleans – killing hundreds and displacing many times more. Everyone knew that New Orleans was below sea level and surrounded by water, with a dike system that needed work. Everyone knew that it was only a matter of time until this kind of tragedy befell the city. Indeed, in 2001, FEMA listed the potential of exactly this scenario among the three likeliest, most catastrophic disasters facing this country. And yet here we are, pointing fingers, finding fault and spending billions to mitigate what we can in the aftermath of this terrible tragedy.

I mention this not to find fault with the way this disaster was managed, but rather to highlight the troubling proclivity of our society to ignore well recognized problems until they have become catastrophes when our only recourse is to invest huge sums to deal with the aftermath of a tragedy which might well have been averted. I share this with you because our nation, by continuing to ignore the growing crisis in our health care system, is courting a disaster of staggering magnitude – a disaster that is imminently avoidable, but only if we act now and act boldly.

Rising medical costs eat into corporate margins, reducing the capacity of firms to grow and compromising competitiveness in the global economy. They slow the rate of job growth, suppress wage increases for existing workers and foster labor disputes and lost productivity. Today health insurance for the average family costs $10,880 a year – up from $9,950 last year – and, for the first time, exceeds the gross annual income of a full time minimum wage worker.

The rising cost of health care is also having a huge impact on state budgets. In 2003, for the first time, Medicaid exceeded the cost of primary and secondary education as the single largest item in overall state budgets. As this trend accelerates it is literally squeezing out the ability of states to invest in education and other social priorities that are crucial to building a world class workforce.

My point is simply this. We cannot stabilize school funding without dealing with health care. We cannot increase productivity without dealing with health care. We can't remain economically competitive without dealing with health care. And we certainly cannot claim to be concerned about our children's future without dealing with health

care. Why? Because the cost of health care is rapidly becoming the major driver behind our exploding national debt, which has huge and sobering implications for the stability of the U.S. currency and for which our children will have to pay.

The sheer magnitude of this challenge is staggering and difficult to appreciate without an analogy. Let me offer one used by Denis Hayes, the Executive Director of the Bullitt Foundation in Seattle, who puts it this way. "Zeroes are important. A *million* seconds ago was last week. A *billion* seconds ago, Richard Nixon resigned the presidency. A *trillion* seconds ago was 30,000 BC, and early humans were using stone tools. America's national debt is now $7.5 trillion, and it's skyrocketing, even as America's population ages.

While the administration and Congress are preoccupied with the solvency of the Social Security system, the real challenge is Medicare. The Social Security gap is around $5 trillion – which is huge – but it is a long term problem and very manageable if we act now. By comparison, with the aging of the baby boomers, Medicare represents well over $65 trillion in unfunded entitlements.

Yet seriously addressing this problem does not even appear to be on the Congressional radar screen. We are asleep at the wheel here. We seem to have succumbed to a sense of powerlessness and resignation; to a growing belief that the system is so huge and complicated that taking it on seems daunting if not futile.

And, that is exactly the attitude we have to change – because we are running out of time -- incremental change is simply not going to do the job. What we need is a Revolution – not of violence but of vision; not of arms but of ideas. A Revolution through which we replace our resignation with hope – and our disengagement with a new community-based activism driven not by partisan politics but by an unwillingness to accept a system that has become obsessed with the delivery of health care as an economic commodity at the expense of health for the American people.

This is a pending crisis of huge proportions and it demands the immediate serious and bipartisan attention of the United State Congress. But is not going to happen without pressure from the inside – and that is where we come in. Oregon has offered national leadership on this issue in the past and it is time for us to do so again.

Toward that end I have three objectives today. First, is to strip down our current system to its bare bones so that you can see and understand its contradictions and inequities. Second, is to offer a straightforward vision of what our system should look like. And third is to describe a direct action plan to spark the kind of national debate we so desperately need.

Let me begin with a story. A few years ago I took a friend on a raft trip down the Rogue River in Southern Oregon. It was August and the Chinook salmon were spawning with many dead fish on the banks while others still struggled upstream. We drifted by a huge male salmon, a spectacular fish weighing over thirty pounds. He was still pointed upstream, valiantly fighting the current and his failing strength, but having difficulty staying upright. His body was scarred, his fins were broken and worn, patches of fungus covered his back and sides, his great hooked jaw slowly opening and closing. "What is

wrong with that salmon" my friend asked me. "There is nothing wrong with him, I said. He is just dying."

Our society views death as something abnormal, something foreign. We act as though death is optional – and have produced an impressive and almost unlimited array of diagnostic and therapeutic interventions with which we treat disease and disability and seek to combat the inevitable consequences of aging.

This, in turn, has led to a huge industry dedicated not just to the development of new medical technologies, but to the financing and delivery of those technologies for the benefit of individual citizens. And if viewed solely from an individual standpoint, many of our new technologies are, indeed, miraculous. If viewed from a societal standpoint, however, there is a darker side.

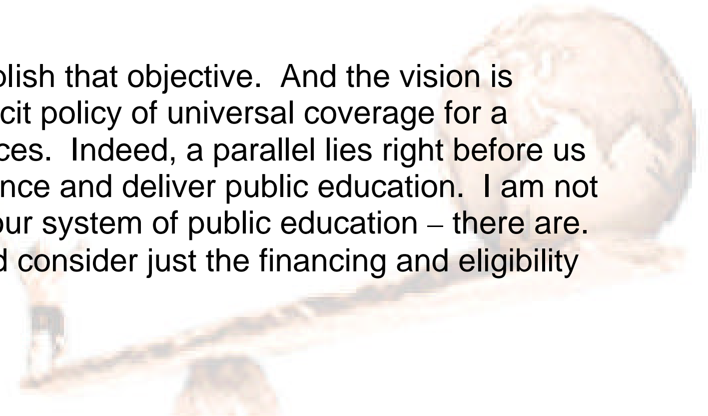
This arrangement would not create a problem if each individual could afford to pay the cost of his or her own health care. But that is clearly not the case. Today we increasingly rely on <u>public</u> resources to finance the cost of care for individuals. In other words, we have created a system which focuses unlimited care and "benefit" one individual at a time while increasingly depending on public resources to finance the cost of that care.

So what is really in contention in the health care debate is the allocation of <u>public</u> resources and who benefits from that allocation. What people choose to do with their after tax dollars is their own business. What we do with public dollars, however, is everyone's business. Let me use an analogy.

One of the consequences of my dual roles as a doctor and as a public official has been an acute awareness of the fact that how I allocate resources as a physician is much different than how I allocate resources as a governor or as a legislator. As a physician, I am committed to treating my patient to whatever extent I deem necessary regardless of cost. As a governor, I cannot ignore cost and my commitment is to provide the greatest health benefit possible for as many people as possible with the resources I have available.

In the public sector we are dealing with resources held in common and they should be used to benefit the larger society from which these resources come. In other words, while you can practice medicine one individual at a time, you cannot build a social allocation policy one individual at a time. The goal is to maximize the health benefit across the population.

So the vision for our Revolution must accomplish that objective. And the vision is astonishingly simple: the adoption of an explicit policy of universal coverage for a defined basic benefit of effective health services. Indeed, a parallel lies right before us worth considering -- the way in which we finance and deliver public education. I am not suggesting that there are not problems with our system of public education – there are. But I want you to step back for a moment and consider just the financing and eligibility arrangement involved.



In the United States we have a policy which entitles all children to a publicly financed education from the first grade through high school because of the widespread recognition of the importance of education –not just to individuals, but to society as a whole. To implement this policy we publicly subsidize our schools with general tax revenues to ensure that they are accessible to all. Everyone who pays taxes contributes to this subsidy – rich people, poor people and middle- income people, people with children and even those who do not have children in school.

And all children, regardless of their economic circumstances, are eligible for publicly subsidized education, and all receive the same "benefit" which, in this case, is the educational experience offered by the primary and secondary school system. There is "universal coverage" for a "basic benefit," or level of education. Nobody is left out. And the public pays for the same benefit for everyone.

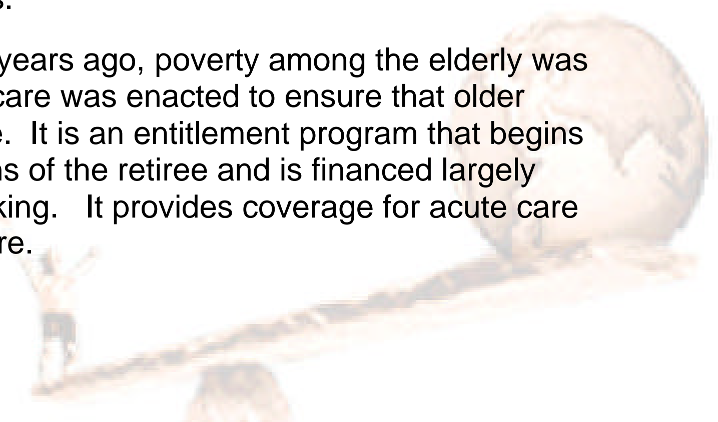
However, parents who wish to give their children additional educational opportunities, a "richer benefit," if you will, – a tutor, enrollment in a private school – can do so <u>but</u> the cost of these additional "benefits" is <u>not</u> subsidized by the general public. And, of course, this option is not available to everyone and is a function of disposable income. Families with few resources cannot afford a private school and must rely on the public system to educate their children.

When we face a revenue shortfall in the school budget, what we argue about is the benefit level. Certainly we complain about how much it costs to educate a child, about administrative waste and the need for efficiency. But at the end of the day, inadequate revenue is reflected in what is covered – in larger class sizes, in a shorter school year, in fewer electives. And this reduction in the benefit applies to everyone who is enrolled in the public school system.

What we do not debate is eligibility. We do not say that, in order to balance the budget, we will eliminate grades 11 and 12 for the next school year; or that we will turn away children over the age of 16; or children whose families earn more than a certain amount each year. In other words, we never question our commitment to universal coverage. Everyone remains eligible for the same basic benefit, even if the benefit must be reduced due to fiscal constraints.

That is a far cry from our current health care system which was built <u>not</u> around a commitment to universal coverage but, rather, around the concept of categorical eligibility. That is, in order to be eligible for publicly financed health care you must fit into a category. These categories were established by Congress with the enactment of Medicare and Medicaid back in the mid-1960s.

When these programs were established forty years ago, poverty among the elderly was twice that of the general population and Medicare was enacted to ensure that older Americans had financial access to health care. It is an entitlement program that begins at retirement, regardless of the financial means of the retiree and is financed largely through taxes imposed on those who are working. It provides coverage for acute care but, interestingly enough, not for long-term care.



While this made sense in 1965, the policies which underlie this program are difficult to justify given the realities of today. Whereas forty years ago the elderly represented one of the poorest segments of our society, today those over 65 constitute the single wealthiest segment of our society, followed only by those between 55 and 65. Because Medicare is not means tested, however, retirees are entitled to publicly financed health care paid for, in part, by workers, many of whom cannot afford health care for themselves and their families.

Medicaid, also enacted 40 years ago, was created to improve financial access to health care for certain categories of poor citizens. These categories, established by Congress, include poor families with dependent children who are on welfare; the blind and disabled; the frail elderly in need of long-term care; and certain categories of pregnant women.

Unlike Medicare, Medicaid is not an entitlement program. Eligibility for Medicaid is based on “category,” not on financial need and thus many poor citizens are ineligible even though they may be deeply impoverished. In other words, our system makes a distinction between the “deserving poor” – those who fit into a category; and the “undeserving poor” – those who don’t.

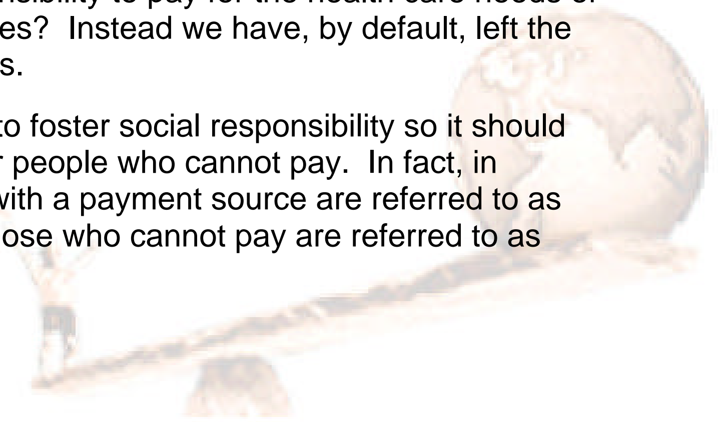
The enactment of these two programs left the U.S. with a public-private financing system comprised of two major third party payers: the government, through Medicare and Medicaid, and the business community, through employment-based insurance coverage.

However, because our system was built around categorical eligibility rather than universal coverage a huge and growing gap developed between its public and private arms. Into this coverage gap fall those Americans who do not fit into a category: citizens under the age of 65, who do not yet qualify for Medicare; who do not meet the categorical or income eligibility standards for Medicaid; and who are unable to obtain coverage through their place of employment.

Today, there are over 45 million Americans in this coverage gap – including 600,000 Oregonians. And this figure does not include the growing number of under-insured citizens who are literally one illness away from personal bankruptcy. Indeed, the inability to pay a medical bill is now the second leading cause of personal bankruptcy in America – second only to job loss.

The gap exists because we have organized our system around categorical eligibility rather than around universal coverage and thus avoided answering the most fundamental of questions: who has the responsibility to pay for the health care needs of those who cannot afford to pay for it themselves? Instead we have, by default, left the economic market to answer the question for us.

But markets are designed to turn a profit, not to foster social responsibility so it should come as no surprise that no one competes for people who cannot pay. In fact, in today’s market-oriented terminology, people with a payment source are referred to as “market share” and we compete for them. Those who cannot pay are referred to as



"liabilities" and, as you know, we seek to avoid them through adverse selection and cost shifting.

The ability to cost shift serves as a kind of pressure valve in the system which reduces accountability – and, thus, the political pressure needed for meaningful reform. And here is how it works. When those without coverage get sick enough, they go to the emergency room where federal laws require that they be seen and treated. But the resulting uncompensated cost is simply shifted to both public and private third party payers through incremental increases in their premiums or their bills.

The third party payers, in turn, shift this cost back onto individuals. States manipulate income eligibility to reduce the number of people covered by Medicaid; while employers drop people from coverage altogether or increase co-payments and deductibles which shifts more out of pocket expenses to employees. And these actions simply increase the number of people in the coverage gap, many of whom are forced back to the Emergency Room repeating the cycle.

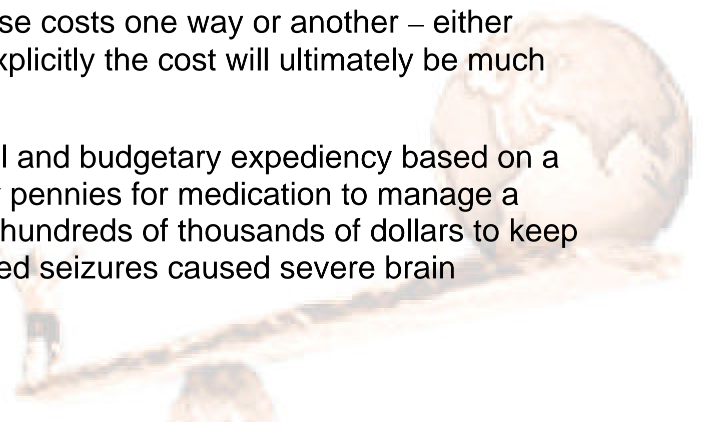
This arrangement not only defies logic and common sense, it costs us far more as a society to treat people in the emergency room than it would to ensure that all of our citizens have access to some basic level of care in the first place. Let me offer a tragic case in point.

In February of 2003, in order to save money, the Oregon legislature discontinued prescription drug coverage for the Medically Needy Program and people on the OHP standard benefit package. As a consequence of this decision, Douglas Schmidt, a man in his mid-30's suffering from a seizure disorder was no longer able to afford to purchase the medication, which controlled his seizures. He was still eligible for state coverage, but the program no longer covered the cost of prescription drugs. He subsequently went into a sustained grand mal seizure and ended up with severe brain damage and on a ventilator in a Portland hospital. He remained in the hospital for several months and was then transferred to a long-term care facility where he finally died in November 2003 when life support was withdrawn.

Now, the cost of his anti-seizure medication was $14 a day. The cost of his care in the intensive care unit was over $7,500 a day – a total cost of over $1.1 million, all of which was billed back to the state. So the legislature did not save any money by its decision. On the contrary, it increased its fiscal liability and, in order to absorb it was forced to drop more people from coverage – perpetuating this kind of human tragedy and fiscal disaster.

My point is simply this: we are going to pay these costs one way or another – either implicitly or explicitly. And by failing to do so explicitly the cost will ultimately be much higher in both economic and human terms.

Think about it. Douglas Schmidt died of political and budgetary expediency based on a policy which says, in effect, that we will not pay pennies for medication to manage a seizure disorder in the community, but will pay hundreds of thousands of dollars to keep an individual on life support after his uncontrolled seizures caused severe brain damage.



It is a policy that says we will not pay to manage hypertension in the community, but we will pay to care for the victim of a massive stroke in the hospital; that we will not pay to provide all pregnant women with good prenatal care, but we will pay to resuscitate their 500 gram infants in a neonatal intensive care unit. And this should not be acceptable to any of us.

But this is not going change if we allow our thinking and our reform efforts to be constrained by a 40 year old eligibility and financing structure which reflects the realities of the mid-20th century. How long would Microsoft last if Bill Gates held onto a ten year old operating system; or a five year old system; or even a two year old operating system? We are clinging to a forty year old operating system and wondering why we cannot meet the health care challenges of the 21st century.

We need to stop simply defending programs and start solving problems -- and the place to start is by approaching our health care system with the same eye to equity and sustainability with which we approach public education. If we did, we would have as our objective a healthy citizenry. To achieve that objective we would adopt an explicit policy of universal coverage for a defined basic benefit of effective health services subsidized with public resources.

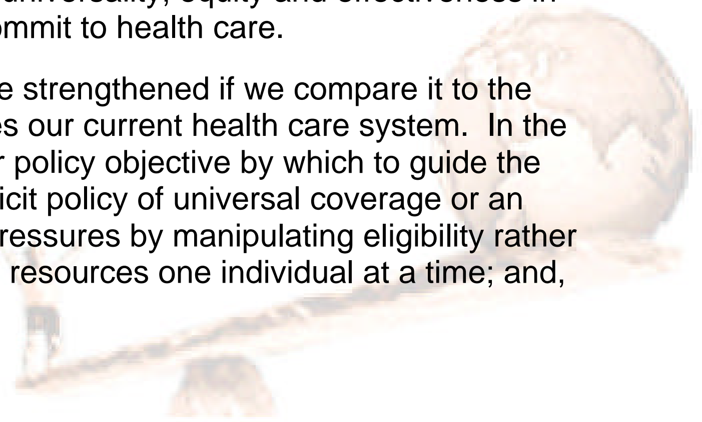
All citizens, regardless of their economic circumstances, would contribute to the subsidy and all would be covered for the same basic benefit. Citizens who want access to health services not covered by the basic package would, of course, be free to purchase them -- but the cost of these additional benefits would not be subsidized by public resources.

Let me be clear. I am not talking about simply moving to a Canadian style single payer system – there are a variety of ways this can be accomplished, but the bottom line is this: we need to demand a different standard for that part of our health care system that is financed with <u>public</u> resources than for that portion that is financed with <u>private</u> resources.

First, we need to demand that we get an actual health benefit for the public dollars we allocate for health care. And second, we need to demand that this allocation of public dollars benefits <u>all</u> of our citizens, not just some of them; that it does not leave 45 million people – including 600,000 Oregonians -- behind.

Using this kind of "public education" model as the basis for financing and eligibility does not presuppose how market forces will be used in the new system, nor does it determine what role might be played by the private commercial insurance industry or by employers. It simply ensures that there will be universality, equity and effectiveness in the way we allocate the <u>public</u> resources we commit to health care.

The case for this public education model can be strengthened if we compare it to the eligibility and financing structure which underlies our current health care system. In the U.S health care system today we have no clear policy objective by which to guide the allocation of public resources; we have no explicit policy of universal coverage or an explicit set of subsidies. We respond to fiscal pressures by manipulating eligibility rather than benefits; we try to allocate our health care resources one individual at a time; and,



we use our limited public resources to subsidize health care for the wealthy at the expense of those who are less well off financially.

And I submit to you that if we were to make the policies which underlie our current system explicit, they would not be acceptable to the American people, nor would anyone in the U.S. Congress openly defend them, let alone vote for them.

To illustrate this point, let's draft a bill that reflects our current system. In other words, if we wanted to enact our current health care system, what would the bill look like? What kind of legislation would the Congress have to vote for?

We will call our bill The Health Care Equity and Empowerment Act of 2006 – because, as you know, in the U.S. Congress the title of a piece of legislation is not required to have anything to do with its content.

It might read something like this.

Preamble

There shall be no explicit policy objective adopted to guide the allocation of public health care resources. No clear responsibility shall be assigned for financing the care for those who cannot pay for it themselves.

Section I

Categories shall be established to differentiate between the "deserving poor and the "undeserving poor."

The "deserving poor" shall include women who are pregnant, families with dependent children, and those who are blind or disabled. Citizens in these categories shall be provided with publicly financed health care.

The "undeserving poor" shall include poor women without children who are not pregnant and poor men. These citizens shall be denied publicly financed health care.

Section II

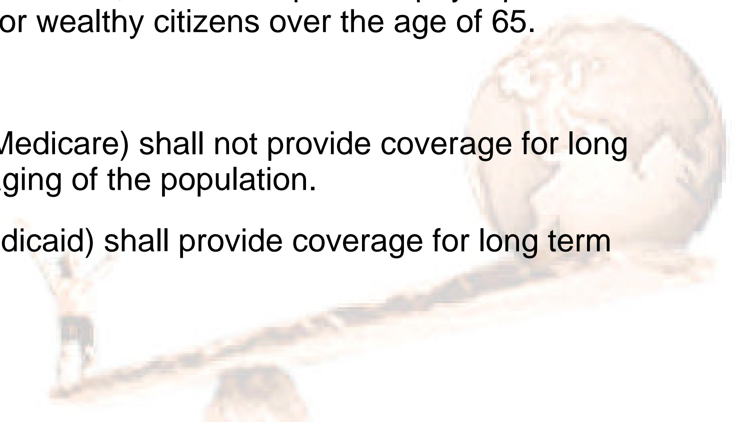
All those who are over 65 years old shall be entitled to publicly financed health care, regardless of their income.

Employed citizens under the age of 65, regardless of whether they can afford health care for themselves and their families, shall be required to pay a portion of their taxes to purchase health care for wealthy citizens over the age of 65.

Section III

The public program for the elderly (Medicare) shall not provide coverage for long term care services – in spite of the aging of the population.

The public program for the poor (Medicaid) shall provide coverage for long term care services.



The elderly in need of long term care shall be required to spend themselves into poverty in order to become eligible for Medicaid at which point their needs will compete directly with those of poor women and children (in some cases their own children and grandchildren).

Section IV

The criteria of financial need and ability to pay shall not be used to determine eligibility for a public subsidy.

The relative effectiveness of various medical interventions in producing health shall not be considered in deciding which services will be paid for by public resources.

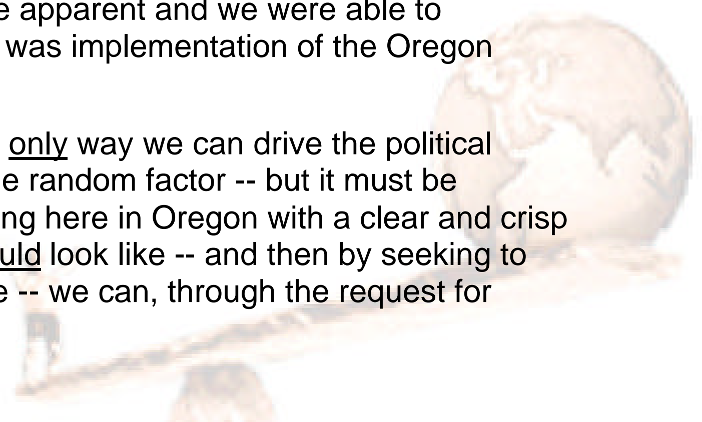
I could go on, but I have made my point. No one could openly support the policies embraced by the Health Care Equity and Empowerment Act of 2006. Yet these policies form the operating system which underlies the larger U.S. health care system – and these are exactly the policies, which must be exposed, challenged and updated if we hope to realize our vision of a more equitable and sustainable system. The question is: how do we go about making it happen?

There is no question but that realizing a new vision for our health care system is going to require definitive action from the U.S. Congress. Bringing Congress to take that action, however, will require the introduction of a random factor that will bring pressure from the outside. And doing so involves three key steps; (1) articulating a vision of a new health care system; (2) exposing the contradictions and inequities of the current system; and (3) creating a tension between the status quo and the vision.

The implementation of the Oregon Health Plan a decade ago offers a real life illustration of the power of this approach. Between 1989 and 1993 Oregon became the focal point of the national health policy debate because we had passed a bill that was illegal – a bill that violated several provisions of Medicaid law – an effort which resulted from the simple fact that Oregon refused to accept the parameters of the existing system. As a consequence we designed what we thought to be a more rational and defensible system, even though we realized that we could not implement it without being granted waivers by the federal government.

But by seeking waivers from the provisions of these laws, Oregon forced federal decision makers to compare the status quo with a different more rational and more equitable vision of how care should be provided to the poor. And through this process, the shortcomings of the current system became apparent and we were able to maximize pressure for change. The end result was implementation of the Oregon Health Plan.

I believe that creating this kind of tension is the only way we can drive the political change that we so desperately need – this is the random factor -- but it must be undertaken on a much broader scale. By starting here in Oregon with a clear and crisp Vision of what the U.S. health care system should look like -- and then by seeking to realize that Vision by a direct vote of the people -- we can, through the request for



waivers -- challenge the entire U.S. health care system … not just the Medicaid program. And that is the challenge I leave with you today – to engage in precisely this kind of effort.

I fully recognize that what I am proposing here is bold and unprecedented --it requires both courage and risk – but it is well within our power to do. William Jennings Bryan once wrote: "Destiny is not a matter of chance, it is a matter of choice; it is not a thing to be waited for, it is a thing to be achieved." And that is exactly the question before us: whether we will shape our own future or simply wait for it to happen to us.

The question before us is whether we still have the capacity and the will in this state to come together as a community. Because if those of us here in Oregon are unable or unwilling to agree among ourselves on a vision for the future, surely we cannot expect it to happen inside the Beltway -- and we are destined to continue to be shackled to the failed policies of the past. By default we will be allowing our future to become a matter of chance, rather than a matter of choice. I think we are better than that.

Albert Einstein once said, "We can't solve today's problems by using the same kind of thinking we used when we created them." That is true. But I think that Edward Abbey -- the late Western novelist -- put it more succinctly, if not as eloquently when he said: "Society is like a stew. If you don't stir it up you get a lot of scum on the top."

Our job, it seems to me, is to stir it up -- to accept the fact that the responsibility to bring about the reform we are gathered here to discuss does not belong to someone else … it belongs to us – to you and me and to citizens in communities across America

This is something we can do. This is something we must do – if not for ourselves, then for our children – a gift for the future -- for those who will inherit the system we have created and which, by default, we are perpetuating.

Let me close with the words of Oregon poet Kim Stafford who eloquently defines the challenge, the opportunity – and, indeed, the responsibility -- that lies before us in what he calls "Lloyd's Story." Lloyd Reynolds, the international citizen of Portland, spent his last days in pain, silent, unable to speak or to write, lying in his hospital bed. On his last day at home, as his wife scurried to pack his suitcase for the hospital, Lloyd made his way outside to the garden and there she found him on his knees, with a spoon, awkwardly planting flower bulbs. "Lloyd," she said, "you will never see these flowers bloom."

He smiled at her. "They are not for me," he said, "they are for you. The salmon coming home? They are for you. The calls of the wild geese? They are for you. The last old trees? They are for you and your children, to the seventh generation and beyond. They are all blooming into being for you."

That is our challenge today. To plant the seeds of tomorrow; to change the world by acting, by leading, by personally reengaging in this struggle -- not as victims of the status quo, but as architects of a new future.