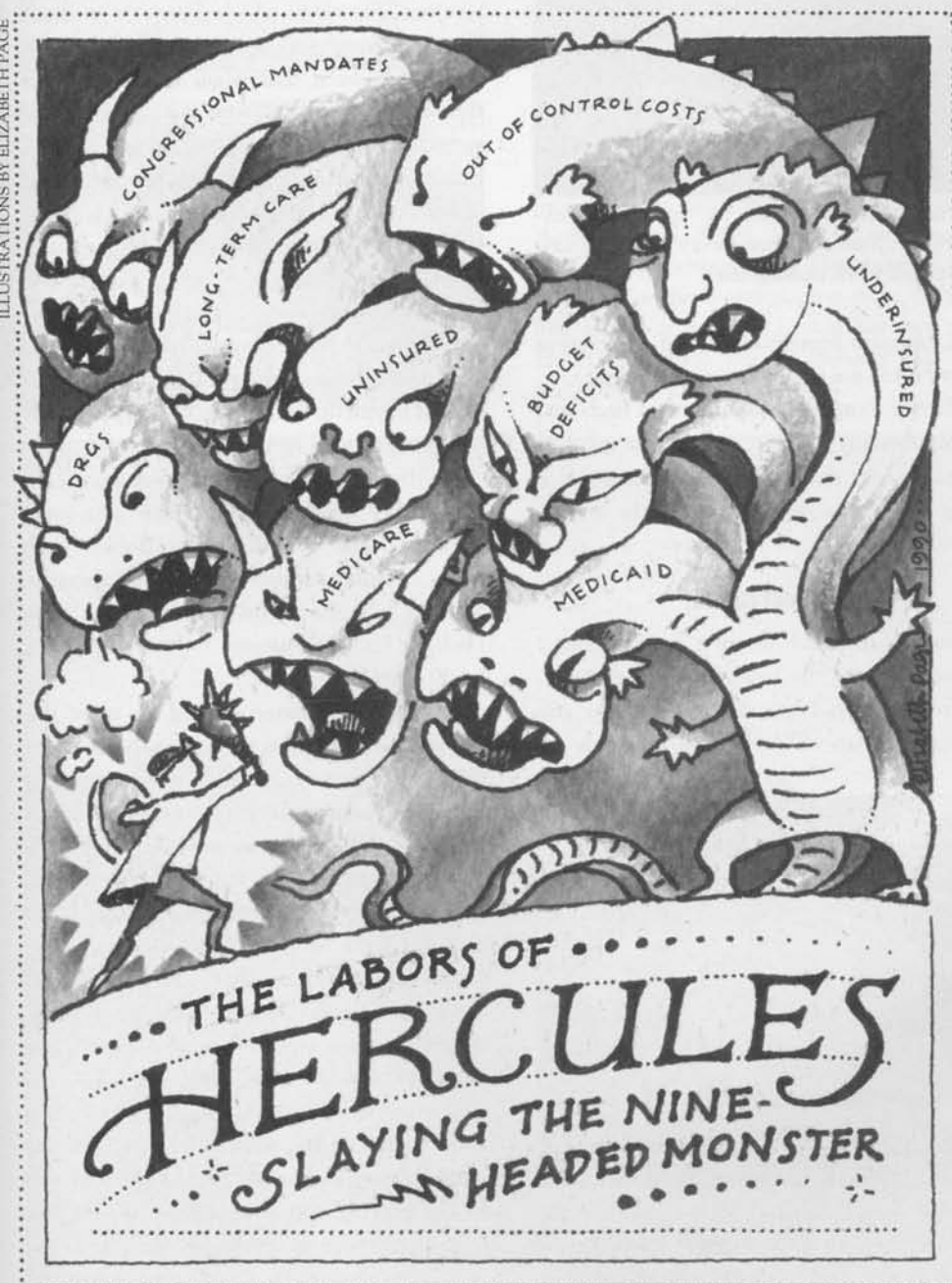


A Herculean Task

By John A. Kitzhaber, M.D.



**A Dartmouth College graduate,
a physician, and an Oregon state senator,
Dr. John Kitzhaber has taken up battle
in a potentially far-reaching way
against some of the
monstrous problems facing medicine.**

Dr. John Kitzhaber, a 1969 graduate of Dartmouth College, has risen to national prominence as a result of his efforts to reform the health care payment system in Oregon. He earned his M.D. from the University of Oregon in 1973 and has practiced emergency medicine in Roseburg, Ore., since 1977. Also a member of the state legislature since 1978 and president of the Oregon senate since 1985, he has been instrumental in developing a way of prioritizing health services in Oregon to ensure that available state monies get spent in the most efficacious way possible.

The initiative, which has received widespread press coverage, has been charged by some as setting up a divisive, two-tier system of access to medical care, but has been hailed by others as a forthright and promising way of dealing with concern about rising medical costs and uncertainty about the value of various medical procedures.

Here is Dr. Kitzhaber's explanation of the innovative plan.

I would like to explain both what we're doing and what we're not doing in Oregon, because those who have shaped their impressions of the Oregon Basic Health Services Act from the public media probably don't have a very accurate view either of our intentions or of the program itself.

First, a bit of history. In 1987, a seven-year-old boy named Coby Howard died of leukemia at about the same time that the Oregon legislature decided to discontinue funding major organ transplants under the Medicaid program — in order to be able to fund, among other things, an expansion of the prenatal and well-child programs. What was already a smoldering discontent with the health-care system — an unease characterized by frustration and a sense of inequity — was fanned into flames by this event. The media and an outraged public perceived that the life of a child had been sacrificed to a political decision. But what the public did not see in 1987, and clearly does not see yet, are the *thousands* of children who die daily in this country from malnutrition, neglect, and a variety of preventable diseases. The implication in the 1987 case of Coby Howard was that more money would have avoided the tragedy. Yet funding that one transplant, which may or may not have saved a single child's life, clearly would not have solved the health-care crisis confronting this country — and in many ways would have compounded it.

Ironically, both the few highly-publicized and dramatic deaths like Coby Howard's and the many silent and undramatic deaths that occur daily can be traced to the same cause. And that cause is not a lack of money, but rather some fatal, systemic flaws in the American health-care system.

Flaws in the system

In 1990, Americans will spend \$650 billion on health care. Yet 19 countries have lower infant mortality rates and 26 have better cardiovascular statistics. American women are seventh worldwide in life expectancy and American men are tenth. The most popular explanation for these dismal statistics is that 30 to 35 million Americans lack health insurance. But even if we focused our health policy on the 30 million people outside the system, we would solve neither the problem of access nor the problem of cost. That's because we have continued to assume that *health care* is synonymous with *health*. I submit, however, that health care is a means to an end but not an end in itself.

Our poor health statistics are certainly due in part to the problem of access, but I think more to a failure to deal with a variety of other social conditions that also have a profound impact on health. For example, women fail to get prenatal care not just because they don't have insurance but also because of transportation barriers, communication barriers, lack of day care, and a variety of other difficulties. And infant mortality rates reflect not only a lack of prenatal care but also housing problems, nutritional problems, environmental problems, teenage pregnancies, and the rising rate of substance abuse. In fact, many of the problems we treat in the medical system have social rather than med-

ical causes. If we found more effective solutions to these social conditions, we could eliminate a whole array of diseases and injuries. In many cases, investments in health care probably don't have nearly as much impact on health as do investments in housing or education or nutrition. Thus, we need to ask whether the objective of our public policy should be to give everyone access to health care or to keep everyone healthy.

The current system is also based on a number of illusions — illusions that we must dispel if we hope to deal with the problems of cost, access, and declining health. These illusions include, first and foremost, the view that resources are unlimited. They also include the illusion that all medical interventions are of equal value and effectiveness; the illusion that we can satisfy the public expectation for health care without paying for it; and the illusion that we are not already rationing health care in 1990.

A genuine solution

To distinguish illusion from reality and thus move toward a genuine solution to this problem, it is important to understand how these illusions arose. I'd like to do that by using an analogy. In a classic essay called "Tragedy of the Commons," published in *Science* magazine in 1968, Garret Hardin described a common pastureland in an English village. Each villager had the unrestricted right to place any number of animals on this common pastureland, and any benefits that accrued from an individual's animals — be it milk or meat or hides — belonged to that individual. In other words, the individual derived a private benefit from a common resource without having to give anything in return.

The tragedy of the arrangement is that it's based on the false assumption that the carrying capacity of the commons is unlimited. It also encourages the individual to concentrate solely on his or her own benefits and to ignore the costs that make those benefits possible. And because it provides every incentive for individuals to profit from a common resource and no incentive for them to contribute to its maintenance, it encourages abuse. So this idealistic system is on the road to ruin from its inception, because it privatizes benefits and commonizes costs.

That's a very apt analogy for our health-care system. We started to privatize benefits and commonize costs in 1965 when we enacted Medicare and Medicaid, which institutionalized the expectation of universal access to the health-care system. At the same time, there was rapid growth in private-sector health insurance policies. And because our fee-for-service reimbursement system allowed us to shift costs, people who weren't covered either publicly or privately were still treated; the cost of that care was just shifted to the public sector and the private sector by incremental increases in insurance premiums or in bills.

While widespread third-party coverage and cost-shifting certainly expanded access, they also insulated both providers and consumers from the true costs of treatment decisions. The arrangement gave individuals the illusion that health care was free and that they could expect access to everything the system had to offer — from primary and preventive care to the latest high-tech wonder — regardless of their ability to pay for it. It also insulated providers in the same way, leading them to believe that they could employ any treatment available, regardless of its cost and regardless of whether the patient could pay for it, as long as some incremental benefit might accrue to the patient. As a result, we've developed widely differing practice patterns based on very

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little empirical data about what is actually effective or appropriate.

Thus the advent of third-party/first-dollar coverage disconnected practice patterns and public expectations from the economics of funding them. The system we created in the 1960s and 1970s resulted in unchecked escalation of health-care costs by hiding the true costs from patients and providers. Health-care spending went from \$1 billion a month in 1950 to \$1.7 billion a day in 1990. And that figure is continuing to escalate at three to four times the rate of inflation.

Nobody wants to say no

The problem is that while nobody wants to pay these costs explicitly, nobody wants to say no to the individual patient. Providers consider it a violation of their professional ethics; patients consider such a refusal a violation of their entitlement; and, of course, the plaintiff's bar is there to perpetuate the status quo.

So although health care seems to be free and there were until recently no real barriers to either access or treatment, tremendous costs have been shifted to government and business. As the Medicare and Medicaid budgets and private-sector insurance premiums escalated, the third-party payers began to question their ability to continue to subsidize the cost-shifting and started devising ways to reduce their exposure to it.

It's significant to note that neither the public nor the private sector has ever rejected the principle of universal access. They still pay lip service to it, though by their actions they have created very real barriers to access for a growing number of citizens. Cost-containment measures have neither contained costs nor stemmed public expectations—they simply shifted costs to somewhere else in the system, primarily onto providers and individuals.

The methods used to accomplish this were very similar in both the public and the private sectors. At the federal level, we got DRGs, a prospective reimbursement system that shifted costs and risks to providers. States controlled Medicaid costs by either cutting provider reimbursement rates or changing eligibility standards. When reimbursement was cut below a certain point, providers began to refuse to see Medicaid patients. Even more insidious was changing eligibility standards—redefining poverty for accounting purposes and throwing some people off the program in order to maintain coverage for others and balance the budget. Nationally, the average Medicaid standard is less than 50 percent of the federal poverty level. That means a family of three making more than \$5,000 a year is too wealthy to qualify for state medical assistance in most parts of

this country—a fact that should make us ashamed as a nation, particularly given what we spend on medical care.

The private sector has done exactly the same thing. By contracting with HMOs and other prospective reimbursement plans, costs and risks are shifted to providers. Employers have added co-payments and deductibles and increased employee contributions to health-care plans, shifting costs to individuals. Some employers have dropped coverage for dependents (in fact, the greatest increase in uninsured children over the last 10 years has been from this cause) and some have even dropped coverage for their employees altogether.

On the individual level we're uncomfortable not doing everything we can for a patient, but on a societal level our actions clearly say we're not willing to pay for it. Today, even people with coverage may find themselves underinsured. And for those who have no coverage, the costs are explicit. If you don't have private resources or health insurance, you're increasingly likely to lose access to the system—either because a provider won't see you or because you delay or avoid seeking treatment because you can't afford it. In Oregon we don't have a county hospital system, so emergency departments serve as the provider of last resort, absorbing a growing burden of uncompensated care. The cover article in the May 28, 1990, issue of *Time* was about the wholesale collapse of our trauma system, largely because of this problem.

Rationing of people

The result, in a very real sense, is the rationing of *people*. If rationing is defined as denying coverage for a service, and thus denying service, then when eligibility standards are changed or when a provider refuses to see an individual that person is being rationed out of the health-care system. So every day we ration people in a country that spends more in aggregate and per capita than any other nation in the world. It is rationing that is unguided by any social policy, that is based on no ethical principles, and that does not consider effectiveness or appropriateness of care. In short, it's a system that provides costly and often ineffective high-tech care to some people and care of unproven benefit to many people, while denying care of proven efficacy to thousands and thousands of people—many of whom, with absolutely no media fanfare, will die as a result. And I can assure you, as both a physician and a legislator, that it is very easy to ration *people* from the health-care system, because the consequences in terms of restricted access are not readily apparent to those making the decisions.

Thus the crisis in American health care results

from the convergence of a very complex set of factors. The solution, however, is far less complex, as long as we're willing to bear in mind the crucial distinction between health care and health. The Oregon Basic Health Services Act is predicated on the objective of improving health, and its development was based on the following nine principles:

(1) Allocations for health care must be part of a broader allocation policy which recognizes that health can only be maintained if expenditures in other areas such as education, nutrition, and housing are balanced. (2) The resource-allocation policy must include a mechanism to establish clear accountability for the allocation decisions and for their consequences. (3) All the state's citizens should be assured universal access to a basic level of care. (4) It is the obligation of society to provide resources to obtain that basic level of care for people who are unable to purchase it for themselves. (5) There must be a process to determine what constitutes basic care. (6) The criteria used in this process must be publicly debated, must reflect a consensus of social values, and must consider the common good of society as a whole. (7) The health-care system should offer incentives to use those services and procedures that are effective and appropriate over those that are marginal or of unproven benefit. (8) The system should avoid creating incentives for overtreatment. (9) The funding should be explicit and the system should be economically sustainable.

Tremendous support

Our success in getting our program through the legislature resulted from the fact that we got all the various interest groups around the table and achieved consensus on these nine principles before we worked out the details of the legislation itself. The three bills—Senate Bills 27, 935, and 534—that resulted from this process enjoyed tremendous support. They were supported by the state's largest advocacy group for the poor and uninsured; by the state's largest business coalition; by the AFL-CIO; and by both the Medical Association and the Hospital Association. SB 27 passed the House 57-3 and the Senate 24-2.

Our first objective was to provide insurance for the uninsured. About a third of Oregon's uninsured live below the federal poverty level but are not eligible for Medicaid because of changes we have made in eligibility levels. And about two-thirds of the uninsured live above the federal poverty level but can't afford insurance themselves and don't have workplace-based coverage. SB 27 expands the state Medicaid eligibility level to 100 percent of the federal poverty level, thus defining the poor based on need as opposed to available resources. And once we define the eligibility level, it can't be redefined to balance the budget. SB 935 is a phased-in requirement that employers offer health insurance coverage to workers and their dependents who have a family income above the federal poverty level. There are no size limits on employers who must participate—it includes all employers, even self-employed individuals. They have to cover at least 75 percent of the premium for the worker and 50 percent for dependents. And they have until 1994 to comply, though there are tax incentives for those who comply voluntarily before then. There is a small business insurance pool employers can buy into and a payroll tax as a sanction for non-compliance. The third bill, SB 534, creates an all-payers risk pool for the "medically uninsurable."

These three bills establish a system of universal coverage, with those below the poverty level having access to the state Medicaid program and those above it having access to an employment-based policy with

benefits at least as good as those offered through Medicaid. Essentially what we've done is shifted the debate from who is covered to what is covered. We've said as a matter of law that everyone should have access to the system—now let's talk about what services they should have access to.

Establishing priorities

A Health Services Commission created under SB 27 is charged with prioritizing health services. It is an 11-member group with representation from both the provider and consumer communities. They are appointed by the governor and confirmed by the Senate, after public hearings. There are five physicians, a public-health nurse, a social worker, and four consumers, though there's nothing magic about that mix. The Commission is charged with prioritizing health-care services in a way that takes into account both social values and clinical effectiveness and with producing a list that ranks these services based on their beneficial effect for the overall population.

To do this, the Commission first held 50 public meetings to develop

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consensus on the health-related measures of quality of life—such as weakness, pain, visual problems, and so on. They used a modified version of the Quality of Well-Being (QWB) Scale developed by Dr. Robert Kaplan of the University of California at San Diego. There was very good participation in these meetings. In addition, we had an active outreach effort to make sure that low-income individuals were involved; we did site surveys to reach people who were bedridden or economically or educationally disadvantaged; and we conducted a scientific telephone survey to check the validity of our results (interestingly enough, most people in Oregon, regardless of their income, own a telephone).

Then the Commission took a list of some 1,600 standard procedures and determined for each one the potential outcomes. They used the medical literature and panels of providers to establish such factors as years of expected survival and alleviation of the symptoms on the QWB Scale. They ran this all through a complicated computer formula to come out with a ranked list of procedures—from the ones that provide the greatest benefit to those that provide the least. This is the stage we are at right now. The Commission has done the first computer run, and though it had some obvious problems it was promising. They will be doing repeated computer runs and fine-tuning the methodology,



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and I think they will come out with something that is quite credible.

Next, this list will be given to an independent actuarial firm that will attempt to assign a cost for providing each procedure in the context of a managed-care delivery system.

This list, with the actuarial data, will then be given to the legislature, which is statutorily prohibited from changing the order of priorities as established by the Health Services Commission. Rather, we must apply the available funds to the entire covered population, starting at the top of the service list and moving down as far as our budget will allow. But everyone in the statutorily-defined population will receive the same benefit level.

At this point there will obviously be a lively debate about the services on the margin, and this is where the charge arises that we're establishing a program to ration health care for the poor in Oregon. And that's certainly true. But we're not *establishing* a program to ration care or *creating* a two-tiered system. We are *changing* the way in which we currently ration care and *accepting* the fact that we already have a two-tiered system. For let there be no doubt about the fact that we currently ration care. In my 12 years in the legislature, every time we have reached this point, instead of evaluating the services based on effectiveness or priority or what society wants out of the health-care system, we have simply cut off people. When we run out of money, we say, "Well, you're no longer poor so you lose access—not just to one or two things but to *everything* on the list." Strangely, we seem to feel more comfortable doing that. We've convinced ourselves that it's more ethical to deny *all* services to people we don't know than to deny *some* services to people we do know. But I believe it's better to confront these tough issues and be accountable rather than just wink and let things occur by default.

Facing the problem honestly

The honesty with which we are trying to face this problem is, I think, going to create a very constructive dynamic in the legislative process. Since funding is explicit, if we want additional benefits we are going to have to either raise taxes or take the money from other programs. If we decide to raise taxes, the tax debate becomes much more focused. It is not just more money for "government," it is more money for specific services. The debate will also be aided by the existence of at least some information about the efficacy of those services and the value society puts on those services. And if we do not want to raise taxes and decide to take money from another program, then we are forced, for the first time, to consider the services' relative benefits

—to ask, for example, if it is more important to do bypass surgery or to keep 1,000 kids in Head Start. It forces us to have a debate dealing with *health* instead of just purchasing *health care*; it makes us weigh the health implications of funding decisions outside the health-care budget; and it creates a kind of accountability that currently does not exist.

Once consensus has been reached on this package—that is, once we have decided that this is the amount of money the state can allocate to health care as opposed to education, corrections, or the other things the state must fund—then this is the minimum package of benefits that the private sector is also required to provide.

Hard-and-fast contract

At that point, the state would contract with providers to offer these benefits in a case-managed system. Current thinking is that the case managers would be primary-care providers. They will contract to provide the agreed-upon set of benefits for a certain group for a one- or two-year period. The contract will guarantee that even if the state runs out of money—if there's a huge revenue shortfall during the contract period, for example—we can't arbitrarily reduce provider reimbursement. We are making a hard-and-fast contract just like any other private-sector contract. For example, when the state of Oregon signs a contract to buy computers from IBM, it can't just decide halfway through the contract period that it won't pay for the rest of them. But we do that now in the health-care system; there is no predictability for providers. In the future, if there is a revenue shortfall, we would have to renegotiate the contract and possibly reduce the covered services.

It is also important to note that we have built a liability shield into the bill which attempts to provide a statutory distinction between medical malpractice—actually practicing bad medicine—and not providing something that falls below the cut-off for services.

We have very strong support from the provider community not only because they are interested in stabilizing reimbursement rates but also because they have been forced to become the rationing instruments for a society that refuses to recognize that rationing is occurring. Our plan creates a situation where allocation decisions would be made at the societal level, allowing providers to be patient advocates within the context of the resources society makes available.

We are now in the process of trying to get a federal Medicaid waiver for our program. We need a waiver because our prioritization will not necessarily recognize all the federal treatment mandates. In

fact, the states are being wiped out by these mandates. For example, there is a current mandate that says if a child under 133 percent of the government poverty level is diagnosed with leukemia before age six, the state is required to pay for treatment. If the diagnosis is made the day after the child's sixth birthday, it's not covered unless the family's income drops below that state's eligibility level. It's "Happy Birthday! You're suddenly no longer poor." I don't know how Congress justified a distinction between a sick five-year-old and a sick six-year-old. But they did, and the only way we can fund it in Oregon is to reduce eligibility for children over six or for pregnant women above 133 percent of the federal poverty level. That's how these mandates work.

The National Governors Association passed a resolution a year ago that was signed by 43 governors; it asked Congress for a two-year moratorium on new mandates because they were devastating state budgets. Just two months later, however, we got a set of new mandates. And you must remember that the Congress that gave us these mandates spent \$150 billion more than it took in and refused to raise taxes, yet passed a whole series of mandates on to the states—essentially saying, "You raise taxes in order to fund these programs."

Certainly it is possible that we won't get the federal waiver—at least initially. Our options are to adopt the plan anyway, in which case we will lose about \$150 million a year in federal matching funds. (Actually, if there are many more mandates it may be cheaper to give up the federal money and just pay for Medicaid from the general fund.) In fact, if we don't get the waiver initially, we will continue to refine the prioritization process. Then we can reapply for the waiver in the next session of Congress after we have responded to some of the concerns that came up during this first effort.

I do want to emphasize that this program is not yet implemented. The legislation has been passed and signed into law. The Health Services Commission is working on the prioritizing. We have been dashing back and forth to Washington, D.C., working on the waiver. But we are far from finished.

And it's also important to point out that even once the program is implemented the effort will be ongoing. A lot of people evidently perceive this as an end product rather than a process. Once it is implemented we will begin all over again—reevaluating, reprioritizing, and modifying the methodology, based on new information on effectiveness, based on new technologies, based on changing public values. The effort will be ongoing, but removed from the legislative process. The idea is to separate the prioritization process, which hopefully will be fairly objective, from the resource-allocation process, which is clearly political.

Starting at the state level

Many people have asked why we are doing this at the state level and not the federal level. Certainly there are disadvantages to that. You could argue that an employer mandate in Oregon puts our businesses at a competitive disadvantage with businesses in California or Washington. That's a valid concern. There is also the problem that people might leave Oregon to get a service that we don't cover or move into Oregon to get basic services that aren't covered elsewhere. There is another potential problem in the fact that our legislation covers only full-time employees—defined as those working more than 17.5 hours a week—so part-time and seasonal workers may fall through the cracks. Another crack in our program is in meeting the needs of those who

have lost their jobs and will not qualify for Medicaid until their unemployment benefits run out, yet will no longer have employment-based coverage. Those are all difficulties of trying to do this at the state level.

So certainly there are some mistakes in our program right now, and we'll have to continue to correct them. But the only mistake you can't correct is the one you never make because you're paralyzed into inaction. That is the situation in Washington, D.C. I don't think any of us in Oregon feel that we have come up with the only way to approach these problems, but until we force a debate on the inequities in the existing system we won't solve them.

Nonetheless, the debate is being conducted at the state level as opposed to the federal level because I am a state senator and not in Congress. And we're dealing with just Medicaid and the uninsured—and not Medicare—because Medicaid is administered through the states, whereas Medicare is funded entirely by the federal government. I would love to bring the debate to the federal level, and in fact we have put it on the national agenda. Congress knows who we are and what

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we're doing. Some of them like our plan and some of them hate it. One of the reasons they hate it is because it is forcing a comparison between the system they created and an alternative.

National action needed

But the federal level is clearly the place the system needs to be fixed. This debate should be conducted nationally, and there should be more people advocating this kind of approach besides a country doctor from Roseburg. We need to have professional associations, medical societies, and other states' delegations begin to question the federal system and propose alternatives. In fact, the Massachusetts Medical Society just endorsed our waiver; there'll soon be a resolution to do that at the AMA level; and I'm trying to get an endorsement from the American College of Emergency Physicians. We need support from these larger groups, and we need it soon.

Note: The AMA House of Delegates voted at its annual meeting in late June to have the American Medical Association lobby in behalf of the federal waiver for Oregon's plan. While the resolution stopped short of actually endorsing the plan, "the AMA was giving its tacit approval to Oregon's plan," reported the weekly American Medical News. ■