

**Health Care Systems & Higher Education**  
**College of St. Catherine**  
**October 27, 2008**

Our topic today is the future of health policy and how we in Catholic higher education and health care delivery can best prepare to influence that future. My task is to set us up for a dialogue on the subject so that by 2:15 pm we are ready to change the health policy world on which the rest of our colleagues at this event depend.

I was asked to do this because I am the only three-term Republican United States Senator who is currently employed teaching health policy in a Catholic University in America. I may also be the only former Republican Senator of any kind who has already cast his 2008 presidential ballot for Barack Obama and Joe Biden. Neither of those qualifies me for this job. But it does qualify me for "optimist of the year."

I am a 1955 graduate of St. John's University, born to Catholic college grads in the middle of the depression. When I was all they could afford to have. A time in the history of our country not unlike today. I was a difficult delivery and received the sacrament of Extreme Unction earlier in life than most people I know. That made me an expert in both health care delivery and optimism. I've been at the University of St. Thomas since leaving the Senate in 1995 and have become a great believer in the role that Catholic Universities should play in health professions, policy and legal system education.

Since I missed the 1932 election of FDR, I can say that none of us has ever lived through an election at a time when 80 percent of the voters in this country think the country is headed in the wrong direction. Our national debt is in double digit trillions and the governments fiscal deficit this year nearly a half trillion. The financial services industry is in shambles taking both the private and the non-profit sector, which has become totally dependent on it, down with it.

After decades of substituting corporate equity and home equity for savings, America's working families and retirees find themselves close to having none of the above. Just at a time when fuel prices have tripled, food prices have doubled along with health care premiums, housing costs and college tuition.

Reminds me a lot of the years that launched me and a Republican majority into the U.S. Senate from 1978 to 1980. The American ambassador and his staff were hostages in our embassy in Iran, Russians invaded Afghanistan so we boycotted the 1980 Olympics, there were great long lines at every gas station in the country, Inflation reached a high of 14.3 %, interest rates went up to 22 %. On the day in November 1982 I stood for re-election the first time, unemployment in MN was at 11 %. Sounds grim to me. But we survived. And we will this time as well.

Some of the same tough medicine President Reagan asked us to swallow in the early eighties our new President will ask us to swallow – but in larger dosages. One thing will be different. Reagan started by saying "If not now when, if not us who" and we soldiered through. For about six-eight years. We survived the energy supply crisis and talked conservation. The Berlin Wall came down and so did the Soviet Union. We even reduced the marginal income tax rates from 70 to 28% and broke the back of inflation. But it didn't last.

We didn't learn the lessons of thrift and the importance of markets that deliver value for money, or the important role of government in assuring consumers that markets work best when playing by rules that hold producers to account.

The last three decades of growth in our health care system have been equally exciting. The medical industrial complex grew larger and larger. Starting somewhere in Tennessee, the privatization of hospitals and medical clinics became the market-based solution to containing healthcare costs. The traditional state-based health insurance companies and the new HMOs began to merge with each other or convert to for-profit health insurance companies.

Before long we had a national health insurance industry with a half-dozen dominant players, none of them playing by market rules because their only supervision lay in state reserve and consumer-protection requirements. Medical

technology companies ground out new drugs, devices and diagnostics almost daily. The added direct-to-consumer marketing to their successful efforts to stifle national policy efforts to do comparative or cost effectiveness research.

The Congress worked to change payment policies in Medicare so as to restrain cost growth in hospitals. We also tried to prospectively price the services provided by doctors, but learned the same prospective payment policy wouldn't work. Docs just prescribed more medically unnecessary and inappropriate services, including overuse of hospitals especially in the last 24 month of life. Medical associations used "patients' bill of rights" to keep third parties from restraining unnecessary utilization, then called evidence-based medicine "cookbook medicine." Increased technology specialization led to costly competition between hospital and specialty physicians and excessive deployment of medically unnecessary procedures.

Employers tried hard to fill the gap as prudent purchasers with Bridges to Excellence and Leap Frogs. But gradually American business went global, self-insured, bought third party payers, forgot that all health care was local and that buying locally was a lot more effective and less costly than buying nationally. The 1992 election was about health care reform and the result was a 1350 page proposal by President Clinton which included every good idea under the sun.

It failed because "contract for America" Republicans didn't want it to succeed, and because the Clinton's were unwilling to consider alternatives from what was left of the traditional bi-partisan health reformers in the Senate known by then as "Mainstreamers." Of which I was one.

Here's a health policy reform memory. (play the Hillary Clinton tape after explanation of setting)

I'll come back to Hillary in just a moment.

In April of this year, I invited 40 veterans of the 1993-94 Clinton health reform to gather in Minnesota and focus on what they recommend be done to "get it right" in 2009. They worked with 40 people in leadership positions in the current healthcare delivery system. By the end there was much more consensus than anyone might have believed possible given the fact so many were polar-opposites 15 years ago.

One thing everyone agreed on is that what each of us saw 15 years ago in the heat of reform depended on where we stood; that conflicting GOP and Democratic political goals made bi-partisan consensus impossible; that each of us would do anything we could to help the next President and Congress to get it right for a change. We did not try to agree on a reform plan.

We did agree that the role of the President must be to give the public a sense or a vision of what we can be as Americans using our distinctive approach to health care delivery and financing. That the role of the Congress is to begin now to build bi-partisan bridges to a specific set of policy reform goals. Senators Ron Wyden (D-OR) and Bob Bennett (R-UT) have such a bridge. Ted Kennedy is reportedly doing the same. That the role of the medical technology and insurance industry is to determine now what it is that each specialized self-interest is willing to give up and what it is willing to contribute to make possible achievement of a common good. And, that a new administration must make clear what we the public stand to lose, if the vision, the policy, and the common good is not achieved.

How can our Catholic health systems and colleges prepare the way to health system and policy reform? I suggest we do what we do best. Draw on the strengths of these United States, of Catholic social teaching, and the example of those in leadership in the field during the years of rapid change in healthcare.

There are many things right with America. Ron Simms, the elected CEO of King County, WA has engaged his Seattle- Redmond community for several years in healthcare transformation. He says it well when he says the genius of America lies in the fact that we are the only nation without a common gene pool.

We are also a government of laws rather than of men. Our constitution and our unique representative government allow us to impact policy leadership one person at a time, not one political party at a time. It may be easier in other developed nations to improve education or healthcare quality by electing the political party that promises to spend more money. Or to contain the growth in costs of healthcare or education by spending less.

But ours is also a pluralistic society in which citizens and immigrant non-citizens alike value choice so long as they have the ability to make a choice. When properly guided by rules, the American corporation (private and public) has done an excellent job in providing so much more and so much better for us to have.

We also have a unique federal system in which all powers not delegated to the national government are reserved to the 50 states. The states deploy value judgments and service access through a wide variety of local governments. It's true that the Supreme Court has interpreted the general welfare clause of our national Constitution so broadly that there is hardly anything over which our national government does not claim jurisdiction. States and local communities, however, have the ability to better reflect the needs of people we all serve. If only they had the financial capacity to do so which could come if the next President re-focused us on their potential strengths. Catholic social teaching calls that subsidiarity, and believes it is often the best route to equal justice for all.

Americans have one thing in common. We are a people of faith. In large part, we have our immigrant roots to thank for this and they keep growing. We also have our founding fathers and mothers and the First Amendment to the Constitution's freedom of worship and the expression of that freedom in a rich tradition of mission-driven non-profit enterprise.

As Catholics we inherit a tradition of social teaching which reinforces the dignity of the human person and the rights and responsibilities of individuals and institutions; the dignity of work and the rights of workers; the call to family, community, and participation in these and in government; the principle of solidarity and its preferential option for the poor expressed in policies of equality and justice, and an intergenerational commitment to care for creation; and the principle of subsidiarity which calls us to find public policy at the level of government which enables as many as possible to be involved.

The Democratic presidential candidate and the Democratic party has wisely backed off the 1993 Clinton promise of passing legislation that would give everyone a plastic health insurance card. Universal coverage has become universal access and that sets the policy course in a more appropriate direction. The Republican candidate continues the Bush policy of increasing the role of cost-sharing accountability by people like us for insurance and medical service choices. It will not work because we have neither information or financial resources to do it.

Earlier this week I attended a fundraiser in Minneapolis put on by the Obama people for Hillary Clinton's debt retirement. As a guest of the host not as a contributor. Clinton was asked about the chances of major health policy reform given the economic and fiscal challenges facing the nation. She responded by saying that reality requires an investment in health care improvement, but not a full expansion of health care coverage. For the time being that makes sense. But what does it mean.

I believe Republican and Democrat Health policy advocates have more in common when focused on needed investments in health system change than in costly efforts at universal coverage. Consider some of the challenges we face in public policy terms: (2 PowerPoint's)

I suggest now we talk about what we as Catholic education and health systems should DO and should ADVOCATE that expresses what we see as the strengths of mission-driven public service. This is a way to think about policy in terms of relationships which express the way may of us think about the key elements of health care, financing and delivery.

At the end I will leave you with a set of policy principles which I have evolved over decades of efforts at systemic reform which you may, or may not, seek to use to think about both health care reform and education reform.

The policy **principles** critical to reforming the medical industrial complex.

**Payment Policy.** "American medicine is remarkably inventive. If pointed in the right direction it will steadily raise effectiveness and reduce cost, as most other productive industries do today." Nothing is more important than how we provide incentives to physicians to continually improve value by more efficient outcomes. 18 months to Medicare Part B reform.

**Pricing Policy.** The price of medical goods and services must be a true measure of their cost. Government should not facilitate hidden costs or cross-subsidization. That means DSH, IME/GME, CAH and tweeners should go and public subsidies done specifically and appropriately. Elephant in your room is the non-profit community benefit.

**Education Policy.** Choices are good. Government should expand choices to individuals. To the extent that we must rely on public subsidies for health professions education, it is the student who deserves the subsidy not the educational institution. Ideal is a proposal to use social security system for income-related loans.

**Consumer choice** is enhanced as information increases. Government policy should facilitate the flow of information. We have more than enough information. We have too little knowledge. When and where we need it. HIT and EMR. This includes effectiveness science research, performance registries, using claims data to report on comparative outcomes, community measurement and clinical systems improvement. Etc

**Access Policy.** Government should **guarantee access** to necessary care. Standards of access cannot be open-ended and must be realistic. Because a new treatment is better does not make it worth ten times the cost. Because retail clinics are not directly linked to MDs doesn't make them unsafe. Same applies to the credentialing/licensing system of determining professional competence. Role of community etc.

**Income Security Policy.** America does not have one. We have social insurance programs and tax policies that date to the Great Depression which were designed to meet the ends of another generation and today leaves no seed corn for the present or the future, Long term care insurance. Tax vs. direct subsidy. Health insurance rules.

**Community and Family Health.** It is far beyond the time to re-examine how America defines, educates, deploys, and rewards primary health, medical and long term care professionals. Catholic health educators can re-define nursing.

**Quality.** Government should establish guidelines for quality, but recognize that quality will ultimately be judged by the individual. Health professions societies must lead in defining best clinical outcomes.

**Competition.** Government's role in stimulating competition should be to assure fair market conditions. Anti-trust rules. Gainsharing. Community planning –vs- medical arms race. Health insurance national rules.

(The investment in improvement of which Senator Clinton spoke includes improving medical data collection and the translation of that information into an important variety of uses. For clinicians it can mean bringing the best available research findings and information about diagnostic and therapeutic alternatives for the patient to the bedside. It can mean developing researched comparisons of the effectiveness of various procedures or technologies. Either in a comparative effectiveness center like NICE in the U.K., or, preferably, in NIH grants to academic and other multi-specialty groups to develop the science of effectiveness. (Peter Pronovost's OR check-list and the puny \$3million AHRQ).

It can mean Medicare investments in care management improvement; or in care coordination for chronically ill; or in blending Medicare and Medicaid payments in ways that produce better results for persons in sub-acute and long term care settings. Medicare will invest in new payment schemes such as bundling payments for Part A Hospital and Part B Physician and ambulatory settings. It will likely ask Congress to consider and approve differential payments for physicians based on demonstrable regional practice variation attributable to supply sensitive and preference sensitive care.

There is likely to be an emphasis placed on funding community-based clinics and other forms of access improvement. The SCHIP program is likely to be part of a reform of the Medicaid program which will include alternative, insurance-based approaches to funding supportive services for persons with disabilities whether accident or age.

Reforms in Medicare Part C and D are also on a Democratic agenda. The donut-hole approach to drug benefit design doesn't work. Plus Dems have promised to create a public program which negotiates prescription drug formularies and prices directly with manufacturers to impact the current PBM approach to pricing. They have also promised to eliminate the Medicare Advantage Private FFS approach and to seek ways and means to encourage greater competition among private Medicare Advantage plans and will likely build Special Needs service benefits into MA rather than the current solo Special Need Plan approach.

It will be asked to consider changes in medical liability reform, with particular emphasis on changing the legal liability standard from [patient consent to informed patient choice. I expect that with some encouragement the next administration will invest in medical home demonstrations and, at the same time, launch a national re-examination of primary care. This will lead to encouraging changes in health professions education as well as reimbursement.)