Polls, Miracles, and Heathcare Reform

What patients say they want and what they really mean.

Albert DiPiero, MD

Bold Initiatives by Politicians

These are the most exiting and promising times in healthcare reform. Major figures in healthcare such as former Governor Kitzhaber, Representative Mitch Greenlick, OHSU President Peter Kohler, Governor Kulongoski, and President Bush are moving forward with their respective proposals for healthcare reform. This impressive and ideologically diverse lineup should inspire substantive change.

But this is not the first time that we have had major healthcare reform on the horizon. In the recent past, three major healthcare proposals *actually did* pass into law:

The Medicare Catastrophic Care Act of 1988 was designed to fill long-known deficits in the universal insurance program for the elderly, and required an increase in payment for enrollees in Medicare. The extra premium did not include coverage for long-term care.

The Oregon Health Plan (OHP), originally passed in 1989 by the Oregon Legislature, was designed to provide health coverage for all state residents—at its core was an employer mandate and a formulary for the rationing of services.

California's Health Insurance Act of 2003 also involved an employer mandate as the first step in an incremental reform designed to cover all Californians.

Each of these represented a fundamental, strategic healthcare reform based on a long and careful study of people's needs and stated preferences. These three acts were based on the foundational belief of achieving universal coverage.

Polls of Oregonians, of Americans, and of physicians, consistently reveal broad-based support for universal healthcare and specifically for a single-payer system. Although these programs were carefully crafted on concepts which, according to polls, had widespread support among voters, they all share one thing in common: they were effectively repealed by voters or their direct representatives within two years of becoming law. As we embark on perhaps another round of reform, it would be interesting and informative to understand why each of these bold initiatives were all passed and then rejected.

The Medicare Catastrophic Care Act of 1988 was ultimately defeated because beneficiaries did not want to pay anything extra for catastrophic care—at the time catastrophic care was viewed as a right rather than an extra benefit—and many were outraged that long-term care was not included in the provisions of the act.

In the case of OHP, most people assume voters refused to adequately fund the act, but OHP's Universal Coverage measures were effectively repealed by the voters' direct representatives. OHP was originally passed in 4 parts: The first was to expand Medicaid to all residents below the federal poverty level. The second and third was to establish a high-risk insurance pool and to expand insurance options for small businesses.

The fourth, and the crown jewel of OHP, was a play-or-pay employer mandate requiring all businesses to provide health insurance for all their employees or to pay into a fund. Taken together, these 4 parts would deliver essentially universal coverage. But because the legislature believed people did not want it enough, they effectively killed this fourth part by delaying implementation until it withered away.

California's Health Insurance Act of 2003 was crafted by a coalition of stakeholders and legislators. The act

was repealed by a voter referendum initiated by business interests in 2004, because voters realized both that they would be paying for it and at the same time, be accepting restricted care. In the same election in which Californians repealed the Health Insurance Act, they overwhelmingly passed a measure sponsored and backed by Christopher Reeve: a $3 billion bond measure supporting state-funded stem cell research. Californians took on this new debt for an uncertain, potential future promise.

Despite what people repeatedly claimed they wanted—despite the years of polls showing broad support—these laws failed because they did not fit our cultural framework for healthcare in the United States. I believe these events reflect what I see in clinic every day. People want vitality, vigor, and the hope of immortality. They are highly attuned to any perceived restrictions placed on their personal access to unlimited health, vigor, and life.

The Cultural Framework and Evidence-based Medicine

At a recent dinner, I heard a high ranking administrator in our state's health and welfare division chatting about her recent experiences with the "healthcare system." She expressed indignation at how insurers had denied her friend treatment for cancer. On further questioning, it became clear the friend was denied coverage for a specific cutting-edge therapy. When I mentioned that insurers, including public payers such as OHP, routinely use a process of evidence-based medicine (EBM) to determine appropriate care, she was perplexed. She did not connect EBM—which she strongly supports—with the possibility of restrictions in care. When confronted with its true meaning, she, as with most patients, became acutely resistant.

The healthcare that people want the most—the healthcare they are willing to fund—is not the healthcare that is *proven*, but instead, the healthcare that is specifically *unproven*—offering mostly hope and promise. In spite of polls, the *promise* of access to all possible treatments appears to be more important to voters than minimally covering the uninsured. The three initiatives described above were abandoned because they restricted unfettered access to the latest, greatest, most expensive technologies of *unproven* benefit.

"The Costs are Eating Us Alive"

Besides insuring the working poor, the other argument we hear for reforming healthcare is "the costs are eating us alive." In pre-election polling this sentiment garners support. But *at* the polls people seem to realize that a solution includes accepting some restrictions in care and that perhaps the costs are not their major issue, after all.

I recently talked with a family, a married couple with two children. The husband works in a steady middleclass job that provides health insurance which does not cover routine childhood visits. The parents have determined what they can afford and decided that they will forgo the routine preventive visits and physical exams because, "It is just too expensive."

While healthcare is expensive for most insured families, it is also tax-free—and not the most expensive thing in this family's budget. Like many Oregonians in their income bracket, they have "bought up" in the housing market and then taken on additional debt to remodel their new home.

On average, families around the country spend much more annually on housing (33%), food (13%), and transportation (18%) than on healthcare (6%). The annual premium that a health insurer charges an employer for a family of four is about $10,800, while workers contribute on average about $2,700.

We know a significant proportion of people without insurance are the working poor—and that 20 percent of the uninsured are families with incomes greater than 300 percent of the federal poverty level. One of the fastest growing groups of the uninsured earns an annual income above $75,000. At the same time, 50 percent of Americans distributed across all income strata are responsible for spending $27 billion dollars annually on alternative and naturopathic medications and treatments. That is $27 billion in post-tax money coming directly out-of-pocket (*JAMA*, 280:1569-75 November 11, 1998).

People want vitality, vigor, and the hope of immortality.

All this reveals that many people forgoing different amounts of healthcare can, in fact, *afford* healthcare. These are not people who live and work in poverty but another important group—those who make financial choices regarding where to spend a significant amount of their extra money.

It's the Economy…

There is one more critical reason why voters repeal healthcare reforms. It's the economy, of course. Healthcare is almost one sixth of our economy. Four of the five largest employers in the Portland metro area are healthcare companies. Healthcare jobs are responsible for one of the largest portions of the employment growth in Oregon over the last few years—and during the recent recession one of the only sectors that added jobs. We are a *Healthcare Economy*.

Californians intuitively understood this when they repealed universal care. The high value jobs stem cell research could bring to the state outweighed the cost. At the same time Californians turned down an incremental step at expanding coverage for over a million citizens because they were easily convinced that the cost of the law was bad for the economy—they believed it was even worse for their personal health choices.

As Dr. Kohler, OHSU's President, once said, "Culture eats policy every time." We are not suffering from a lack of astute policy options such as OHP. The cultural message from this debate is more ambiguous and more powerful than policy directed solutions meant to create a more equitable healthcare system.

There are several paths forward that, in this single article, are too complex to adequately explore. Where we go, or what path we take, depends on our objective. One path could be to simply stay the course remain true to the goal of universal coverage and bring people along through the real process of personally, persistently, and creatively engaging them—much like the environmental movement increases awareness around conservation.

Another path involves perhaps redefining the goal of our healthcare system, and finding ways to build on the cultural forces expressed in peoples actual choices and their intuition about the promise of advanced and still *unproven* medicine. With this approach we would promote the science and technologies that foster the most advanced medicine and the most advanced economy. This path counts on a growing economy to improve peoples access to care and on medical breakthroughs to improve health outcomes.

Regardless, any successful, lasting reform will require diligent and imaginative education of the public. And all education must start with self-awareness. Until we understand what we truly want, we will not be in a position to confront the tradeoffs and compromises that are part of any effort at change. Those of us in healthcare are not exempt from the need for further self-education. But clinicians could today fulfill a unique role by explaining the tradeoffs to people in personal terms. Bringing a radical frankness to the public discussion could, with time, lead to greater honesty about our goals and point to a mutual path forward.

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WORTH: What Are We Willing to Pay?

The value or worth of something is what we are willing to pay to obtain it. The price of something is what we actually pay to obtain it. When the value of something is much greater than what we pay to obtain it, we get a good deal (economists call this consumer surplus).

About two years ago, my mother had persistent swelling in her feet and legs that was painful and making it hard for her to walk. She saw her doctor and tried a bunch of things, but nothing helped for over two months. She was distressed, and I would guess that she was willing to spend upwards of $2000 to be rid of the swelling. Then, a nurse told her to buy pressure hose. My mother bought two pairs for about $32, and was rid of the swelling in a week. She was mighty pleased; this was a really good deal. Economists would say that she received lots of consumer surplus.

Reduced mortality gives us extra length of life. The value of reduced mortality is what we are willing to pay for the extra length of life. All of us make decisions—such as the type of work we do, whether our car has airbags and other safety devices, whether we have a smoke detector or not, etc.—that affect our length of life and our wealth. We can analyze these decisions to estimate how much we would be willing to pay for reductions in mortality. There is a large economics literature that does precisely this. The foremost researcher in this field is probably Kip Viscusi of Harvard University.

When we say that the reduced mortality from heart disease was worth over $13 billion annually to Oregonians, we are estimating that Oregonians would be willing to pay over $13 billion in foregone wages, better safety devices etc., to obtain the extra length of life due to reduced mortality from heart disease. It does not mean that we spent $13 billion on reducing mortality from heart disease.

When we say that the value of potential future improvements in health and longevity is enormous, we mean that if, for example, we had the option of reducing mortality from heart disease by another 5 percent by spending more, we would indeed be willing to spend a lot more.

That the value of reduced mortality from heart disease alone has been of a magnitude comparable to all health spending in Oregon shows that we have been getting a good deal on the money that we spend on healthcare. This is not to say that the deal can't or shouldn't be better for consumers. Indeed, it can and should be better. We are trying to say that in all this criticism of the healthcare system, we should not forget that—on balance—the extra length of life and better health we get for our spending are extremely valuable to consumers.

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(As a society we value interventions for life threatening conditions even when the costs are astronomical. Dr. Tina Castañares addresses society's need for more sophisticated analyses, more guiding values, and criteria to make intervention decisions in the Oregon's Future *Healthcare Panel Discussion (Spring 2004). She shares a story of her 97-year old father and how society dedicates huge proportions of our healthcare spending to people in their last few weeks or days of life. —Ed.)*