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Members of the Panel: John Seiberling, Moderator
Sharon Dietzel, R.N.
Janet Hollowat, R.N.
Wayne Jones
Cynthia Snyder
Tom Watkins

Good evening. Thank you for coming to the University of Akron to witness and engage in a discussion on one of the most important issues facing this country. Today, a number of specific proposals were presented for reform of the health care system in America and this evening we are honored to have with us legislators and persons involved in the legislative process representing hospitals, in the Ohio Nurses Association, and the Ohio State Medical Association. They will discuss their efforts to affect legislation that is working its way through the Ohio Legislature. Our moderator for this evening is the Honorable John Seiberling, former member of Congress and presently Director of the Center for Peace Studies at the University of Akron.

John was one of the sponsors of one of the first legislation in this country for national health insurance in 1971, the Kennedy Bill, and it is that same debate and that same type of legislation that we'll be considering tonight. So without more, I introduce John Seiberling, our moderator.

Well thanks very much, I might add that being of the age where I'm now eligible for Medicare and an age where things happen like having to have arthritic deposits cut out of your thumb, I'm acutely aware of the fact that the medical crisis is not just something of someone's imagination or issue in political campaigns. Anybody who has Medicare and the so-called medi-gape insurance knows the horrendous amount of paper work and bureaucratic buck-passing that characterizes our present system. But, that's when you have coverage and as we all know a lot of people don't have coverage. Despite the fact that I co-sponsored the Kennedy National Health Insurance Bill, in all eight terms of my service in the Congress, I am the first to say that I have a lot to learn about this subject, particularly in terms of how we get from where we are to where we want to go; assuming we know where we want to go. One of the interesting things that I learned in studying the issue of peace and how we expand peace in this world is the concept of structural violence. We think in terms of war as being a situation where we have a lot of physical violence but we learn in the peace studies field that whenever human beings are denied the ability of realizing their full potential other human beings may act to remedy it. If this occurs, you have a situation called structural violence. To the extent that people in this country and in the world in general are not receiving the amount of medical care that the person who can afford it is able to receive, we have a form of violence that we morally have an obligation to correct. So I am very proud to be the moderator here

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tonight and we have some outstanding people to discuss this very important issue, a very timely issue. Each of the speakers will be given ten minutes to present his views or her views on this issue and when each one is finished we will then throw the matter open for questions and discussion among the panelists and also between the panelists and the audience.

It is my pleasure now to introduce to you our keynote speaker. Dr. Brendan Minogue. Dr. Minogue did his undergraduate work at Cathedral College in New York and his graduate work at the Ohio State University in Columbus. He also had a post-doctoral experience at Notre Dame under a grant from the National Endowment of Humanities. He is a Professor of Philosophy at Youngstown State University and a leader in the field of Bioethicists Network of Ohio, BENO. He is the former Chair at the A.I.D.S. Task Force, and the former Coordinator of Medical Humanities at NEOUCOM. He is also a Bioethicist for the Western Reserve Care System in Youngstown, Ohio. Brendan is also a long time friend and colleague. Now, I would like to turn the program over to our keynote speaker, Dr. Minogue.

I think it is really important to remember who I am. First and foremost, I'm a philosopher. Philosophers for the most part, are good at what they do when they ask good questions; clear questions, questions that have a chance of being answered, and sometimes questions that don't have a chance of being answered. But today, I would like to talk a little bit about what the right questions are when we go about looking at the reform of health care.

Every philosopher thinks that you can't ask questions without assumptions. We're always asked, what's your background assumption? So, I am going to give you my background assumptions; my fundamental commitments. There are two. They are produced in a massive document called the President's Commissions Report. If there is a secular bible for health care ethics in the United States, this report is it. The volume that I'm referring to is the volume called "Securing Health Care." The President's Commission was started by Jimmy Carter and signed by Ronald Reagan, so there are two sides of the spectrum involved.

Here are the two assumptions. First, all citizens are entitled to an adequate level of health care. Second, citizens should have the right to secure additional services by using private resources. In other words, the President's Commission bites the bullet on health care. Should there be a one tier or two tier system? The President's Commission is clear; two tiers. Inequity is okay, it's morally permissible as long as there is a decent minimum for everyone. The problem is that many Americans are not receiving an adequate level of health care.

I could spend a week telling you about the problems of health care, but the costs are the problem. From 1980 to 1986, GNP grew about 9% per year. Health

care grew 27% per year. Medicare Part A grew 38% and Part B grew at 60%. The cost of insurance for health care for each employee grew at 60%. The 1985 cost of health care insurance for an average employee in the United States was $1700. In 1990, it was $3217. If you project for the next eight years, you're at $15 1/2 thousand dollars per employee.

Now let's look at the national picture. Currently, health care is costing 12 1/2% of our GNP. A lot of money. By the year 2000, we'll spend two trillion dollars on health care. The best medical economist in the United States is Louie Rhinehart. He determined this number. If you look at the current projection, the entire GNP of the United States will be consumed by health care by the year 2060. We're talking a lot of money.

What do we get for all this money that we spend in the United States? We spend a higher percentage GNP on health care than any other country in the world. Nobody even comes close. But, we get roughly equivalent care. Canada, for example, is spending 9% of their GNP and Greece is getting roughly equivalent care at 4% of GNP. What does that mean? Well, these other systems provide universal access; everybody has access to the system. In the United States, however, 14% of our population, 35 million people, have no access to any kind of health care. These 35 million just can't get care. What is really frightening is that 63 million Americans lack continuous coverage. This touches me. I come from a middle-class family. We're okay. But, many of my nieces and nephews are out of health care for three to six months out of the year because they're switching jobs. Employer-based insurance; that's what we've got in the United States. You've got it, you people have employer-based insurance. What's it like? It's full of exclusionary clauses; caps and deductibles that severely limit your access. What's your deductible? Don't tell me it's too frightening. What are the exclusions in your policy? What about previous existing diseases? Don't tell me. I don't want to hear the truth from you because it's too frightening.

So, what's the conclusion? It's pretty simple. Principal one of the President's Commission is not being satisfied. Americans are not receiving adequate levels of health care. What's the solution? About 45 comprehensive plans have been submitted; President Bush, Governor Clinton, the American Medical Association (AMA), The American Hospital Association (AHA), American Association of Retired Persons (AARP), the Health Insurance Association, the Edgeovan Plan, etc. If you break it down, there are only three solutions on the table. There's the national health plan modeled on Canada and the U.K. But they're different. Canada's program is one-tier program which means there is only one provider of health care in Canada. If you have only one provider, you cannot go outside the system. It's as simple as that. If you provide health care outside the national system, you are in violation of the law. The U.K. is different. The national health care system has a second tier. You can get additional services. Second, is the

state-based plan like Oregon, Minnesota, Hawaii, and Ohio. Third, you have the market reform proposals of the AMA, AHA, and the Edgeovan Plan.

Well, what are the questions? First, should everyone be guaranteed a health care plan? I think the answer is yes. I think the President's Commission is clear on this, but not everybody agrees. Second, if you're going to have a universal health care plan, how do you provide universal coverage, how will you expand coverage?

Finally, how can we pay for it? We're already paying for insurance. Should Medicaid be retained? Take a look at the Ohio budget. Everything in the Ohio budget, all the expenditures are either flat or dropping except one, Medicaid. Medicaid is federally mandated. It's the only expenditure that's growing. What are you going to do about long term care? We have not even looked at this question. It's a very tough issue. I think we should consider rationing. I think rationing health care services is the answer. It's Oregon's answer. Oregon lets democracy do it. They formulated hundreds of community meetings and voted on priorities for health care services. They're going to review the priorities every year. But, Bush denied Oregon the Medicaid waiver? If he had given the waiver, the system would have kicked in. They would have taken that Medicaid money and created the Oregon Health Care Program. That would have provided the seed money for starting it. Bush stopped it because they formulated set priorities. The people of Oregon tried, but they were forced to bite the bullet.

So, who do you think should administer the health care program? I think that's the important question and the toughest aspect is rationing. Right now, there is just no top expenditure limit on health care. Limits just don't exist. So, look at the choices.

I want to take my few seconds to express two concerns. First, single payer systems are efficient, they provide great care for patients. But they are weak on research. Medical research is not concerned about patients who exist now. It's concerned about the grandchildren, great-grandchildren; future patients. I think single payer systems have yet to deliver a plan for continued research and development in medicine. Let me illustrate this. You and I, if we suffer depression, will go to a doctor. He will probably give us some prosaic.

Prosaic is pretty decent stuff, it's not the cure-all to the human condition, but it's not bad. It's a start. But, what are we going to pay for it — about a hundred bucks a month. What are Canadians going to pay? Well, the makers of Prosaic will go to Ontario or Ottawa, the central board, and say a hundred bucks a month for patients who you prescribe Prosaic. The Canadian Board will say, "we'll give you two dollars a month or three dollars a month per patient." You know what the makers of Prosaic will do, they'll take it. They'll take it because

they will still make a small profit. What they can't do is pass because the cost of all the failures. You know the failures that were involved in the production of Prosaic? Thousands. Who do they pass on all the cost of those failures to? The hundred and eight million people who pay for pills in the United States. That's because we pay for all the research.

What are the Canadians doing about research? It's centralized research in Canada and that concerns me. My second concern is when you call doctors or nurses gatekeepers. I don't like it. Why don't I like it? Because I think of my physician as having a professional relationship with me. It's a relationship that's best for me. You make the physician a gatekeeper and his commitment to the patient must necessarily decrease. You make the nurse the gatekeeper and the commitment to the patient must necessarily decrease.

I think this is the first time that I have been to a conference talking about health care reform where I have not heard a lot of lawyer bashing. Being the General Council at the Medical School, I feel singularly responsible for all of the lack of health care in this country as well as high bills. I'm told that we are responsible everyday. When I looked at all the different programs presented today, I began to think, "My God, there is such divergence." Where is the commonality? I try to pool together the common pieces of all the programs. First of all, each one of those programs promotes its own bias and protects its own interest. I think that's one thing we need to be very well aware of. But, I think some of the good things that I heard come out today are the issues of infant mortality. If we're looking at the U.S. being 21st in world infant mortality, it tells us that we are not really doing our job.

We really need to be dealing with the big "P's," prenatal care, primary care and prevention. If we can hit hard on those and find the money somewhere to support those particular programs, I believe that we are going to have quite a bit of reduction, not only in costs, but in kinds of problems, the severe problems that we see. I, for example, have a father who smoked for fifty years and is now facing cancer. He has surgery, he has chemotherapy, he has radiation, all of which was very costly not only in terms of dollars, but also in terms of the human costs.

I see lifestyle issues as being terribly important. The use of drugs, smoking, alcohol, driving fast; all of those things are very important in terms of high health care costs. Reducing administrative cost, that seems to be the Canadian answer. Let's reduce those administrative costs. Canada pays 3% of their dollar for administrative cost and it seems to produce an efficiency that is terribly important. How can we make our plan a little bit more like the Canadian Plan? If we want to manage health care cost, we are going to have to make tough choices: we're going to have to do some rationing.

We need to talk about coordinated care. I like the use of coordinated care rather than managed care. I don't mind being coordinated but I do not like to be managed. There are lots of issues that we're facing. Long term care is another place where a lot of dollars are being spent in this country. If we take a look at the amount private and public sector dollars that are being spent on long term care, it's an issue that we know we have to address. We've got to come to some rational means of providing care for the older adults and folks who have chronic problems in this country. What is the role of government, everybody has a different answer.

I think that one of the things we need to really come to grips with is what is the role of government? How much should they intervene? How much should they be involved? Should they be the rationer? Should they be the payer? Should they be the decider? How will we empower them?

Finally, I would like to talk about universal coverage and universal access. Two very important issues. We have not addressed that substantially in this country. It has, as Rakich said, been identified as a matter of right, at least to the basic level of health care. We talked about primary care physicians and the fact that only 14% of the physicians in this country are primary care physicians. That is very frightening. I can tell you that there are many things that go into the choice of whether or not to be a primary care physician. One of them is reimbursement, but that is a very small part of it. Other issues included lifestyle, self esteem, and your peers. I have had an example, just recently where I had a very fine medical student who wanted to be an internist. He wanted to be a primary care physician first and foremost until he got into orthopedics. When he went on his orthopedic clerkship, they said, "What do you mean, your such a bright young man, why would you want to be a primary care physician."

The physicians in this country do not hold primary care physicians in high esteem. We consumers think that they're great because they look at us and talk to us and they're compassionate with us, they want to hear about all our problems. But, their fellow members of the community do not hold them in high esteem. They like the people who deal with all the fancy high tech stuff and people who are doing research.

I think one of the things we need to do is change the way we look at primary care physicians and primary care providers of all types. Until we do that, no amount of reimbursement will do any good. We have been trying for example at NEOUCOM to provide role models for our primary care physicians. We have added clerkships in family medicine and primary care. But, we have people screaming on the other end that we a taking too much time away from surgery and orthopedics and variety of the other specialties. The students we are training now who want to do primary care are not ready to come out on the critical side

yet. It's going to take us time. It is a problem we can handle but we have to put aside some of our own special interests. We are going to have to think about how we are going to handle this problem together in a way that makes sense for this country. Thank you very much.

Next, I would like to introduce John Polk. John is Executive Vice-President of the Greater Cleveland Growth Association and Executive Director of the Council of Smaller Enterprises. The Greater Cleveland Growth Association is the nation's largest corporate Chamber of Commerce and its Business Division serves a membership of 10,000 local businessmen. He advocates Cosie's Health Care Plan. Cosie provides group health care coverage for nearly 8500 companies. Cosie has been cited as a creative, private sector approach to providing affordable health care for small employers and their workers. Mr. Polk has testified at numerous legislative meetings, colleges and universities. It gives me great pleasure to welcome Mr. Polk to our forum.

There are numerous barriers to real health care reform. But, the market can work. The Cosie Plan represents Ted Kennedy's worst nightmare because the liberals in Congress and our State General Assembly want to sell you a broader, more comprehensive, government-based health care reform strategy. They wish to do so on the assumption that the market has failed. Our belief is that market forces have truly not been given the opportunity to work as efficiently and effectively as they might. Until our friends in government are prepared to confront the failure of those public health programs over which they currently have statutory oversight, such as Medicaid, the Bureau of Workers Compensation in Ohio and the Veterans Administration at the federal level, they shouldn't have authority to tell a small employer in the private sector how to modify their behavior. Market forces can be very effective at promoting health care reform if we're prepared to let market forces work.

Secondly, purchasers matter. Any discussion over health reform, generally speaking, involves five players; government, insurers, physicians, hospitals and employers. Whenever you sit and talk with these folks particularly the providers, they will tell you that we are all in this together. This is a shared problem, we must all work together to solve it because we have so many issues in common. That is true. Our issues are all related. The issues facing purchasers and the issues facing providers are related to the extent that they are, by in large, diametrically opposed. Hospitals and physicians are looking to get paid as much as they possibly can. Employers and purchasers are looking to pay as little as possible for as much value as they can obtain. But, the providers, insurers and government, say that these issues are so complex that mere mortals cannot possibly comprehend them. Therefore, employers and purchasers need the help of the hospital community, the physician community, and what we jokingly refer to as our friends in government, to help understand all the complexities involved in

health care reform. Those people are trying to pick your pocket. We believe that powerful, aggressive, knowledgeable purchasers can have a tremendous effect on reshaping local delivery systems.

That leads to the third thing I want to mention. Health care is local. Unless you are the King of Saudi Arabia, you get medical care somewhere nearby. Services are paid for locally as well. This tells me that the real test as to whether health care reform operates effectively is going to be measured in local communities, where people live and work, where they get sick and where they access care. Comprehensive legislation is going to be sufficiently flexible. It will prevent purchasers from designing health care reform strategies that meet their unique problems of the local community. Market-based reform is possible. The existence of our program demonstrates that if employers in the private sector are prepared to think creatively, make tough decisions and stick to them, it is possible to reform local delivery and financing systems with market forces.

One of the reprehensible aspects of the health care debate, particularly in Washington, is the extent to which our elective public officials pander to the ignorance, anger and fear of various constituencies in an attempt to persuade those constituencies that only government is sufficiently capable of creating true health care reform strategies. I would suggest to you that there is ample evidence in such programs as Medicare and Medicaid to show that the federal government has no quorum on the competence market. Whether Medicare works or whether it doesn't probably depends on whether you're trying to sell Medicare as strategy or whether you're trying to get Medicare benefits. Business judgment and market forces can create health care reform strategies that work if we are prepared to be creative, if we are able to make and enforce tough decisions, and frankly, if we have the will to change.

I think we are already at a crisis stage. Our health care system is in a perpetual state of change. There is no single idea and we might as well be realistic about reforming the system. Neither of our candidates for the presidency are being honest with the American electorate. Both of them would like to tell you that it's possible to provide more people with better benefits at lower costs. That's just not realistic, but perhaps our focus on realism is unconstructive. Perhaps we should be more willing to focus on the benefits of health care reform strategies in the abstract. We, as an organization representing small employers, have to operate in the market place as it exists today. Since 1986, when our organization became involved in the health care policy debate, a lot of talking has taken place, on the left and on the right, all of which has done almost nothing to produce true reform in the health care system. Meanwhile, the last five years have seen participation in our health care plans double. Over the next five years, participation in our plans will double again. Unless, of course, our friends in the

government choose to help. I would be very happy to answer any questions. Thank you very much.

I would welcome questions or comments.

Sir, have other groups around the country looked at your plan and are any trying to emulate it in their market?

We have talked in the last year with probably 50 organizations of various sort in the private sector and I have talked to both presidential campaigns, both Houses of Congress, and various work and technical associations. There is a lot of interest in the program. One of the things that I find interesting and unfortunate about the reform debate is that all this talk, all this light noise, all this political pressure, has really made it very difficult and very risky for the various groups involved to behave in any innovative way. You can't get an insurance company to talk with you about market based reform for small employers because they are waiting for the government to establish the rules. Interestingly, I found that insurers have increasingly proposed notions of pay or play and Endovan strategy for health care purchasing corporations. Why? It's because those programs are essentially regulatory in nature and insurers have become comfortable designing plans to meet the specifications of regulators instead of designing plans to help the market. So, we are seeing insurers gravitate towards regulatory reform strategies while free market reforms strategies are something that they are very uncomfortable with.

Sir. We have had markets in health care since 1945. Inflation rates in medicine have approached 26% per year since 1960. The markets have not worked. You want to make a change in the markets and claim it will work. You know it is hard to believe, really hard to believe. There is so much evidence that indicates that the inflation rates have increased because there are no caps on the spending.

Well, that's a big one.

I would suggest that hyper-inflation in health care probably began in the mid-1960's with the creation of programs such as Medicare and Medicaid. That's when the inflation in health care cost really began to accelerate. I would also suggest that governmental control over health care expenditures, as evidenced by such programs as Medicare and Medicaid, leaves mew equally uncomfortable with the notion that government entities and constructs, which have already been demonstrated to be somewhat of a failure in increasing access and controlling cost, will somehow improve their past experience and do it right this time. I would suggest that when Medicaid was established in 1965, it was designed to cover about 80% of its eligible population, today it covers less than half.

I am not certain that's the kind of track record that I want to embrace when focusing on the future of health care reform in our country. Yes...The question is would I make a few comments on managed care as a cost containment strategy.

Interestingly, the biggest opponents of managed care are in the commercial insurance industry. Not on the part of the big insurers, the Signas, the Prudentials and the Travelers. They are big enough to be able to adapt to a managed care strategy. It's the small employers who represent the biggest carriers to managed care. Managed care functions as market share. There are very few small commercial insurance carriers that have any desire to acquire significant market share. Essentially, our managed care plans have become popular because of the cost incentive. Our members can buy managed care plans 15% lower in cost than they can traditional indemnity plans. I think, both in the public sector and the private sector, a key real health care reform is going to be down-sizing the delivery systems, especially in urban areas such as ours where we have about 5000 too many hospital beds. It's probably time to take a look at the enormous excess capacity that exists in urban areas such as ours and use those market forces to squeeze the excess out of the system. I would love to design a plan for our members whose emphasis is on primary care because that's the thing that our system does worst. It happens to be what Canada does best. We have not provided any incentive for physicians to get into primary care and we certainly don't provide substantial incentives for purchasers to access the primary care system. It's a lot easier to spend tens of thousands of dollars on intervention than it is to spend a couple of bucks here and there on primary care. However, state insurance laws do not give us the flexibility to design a plan that would meet our members needs most efficiently. We've got to buy what insurance companies offer and what insurance companies offer is by and large a product of state insurance regulation. It's a terrible situation, one that we continually petition the General Assembly to give us some relief from, but we have not yet been successful.

Our next speaker is Pam Argus. She is a Master of Social Work and a Master of Arts in Public Administration from the Ohio State University. She was Executive Director of the Alliance for the Mentally Ill of Ohio from 1984 to 1990. She is also an adjunct faculty member at the Ohio State University School of Social Work. It is my pleasure to introduce to you Pam Argus.

Thanks. I am very pleased to be here today and I am really pleased that we are having these kinds of discussions. My purpose today is to leave you with some questions. We are very much in the midst of trying to figure out what to do with the health care crisis. We are here today because there is a crisis. That's not news to any of us. I'm here to say that there is something very extraordinary that has happened in the last several months. It raises questions from a different perspective about this issue. We have been in this debate off and on since the

1930's, whether we're going to have health care reform and what it's going to look like. To a large extent, the debate we have had has been driven and directed by certain parts of the system; the provider and the insurance industry as a whole. Attorneys also have a role. Most of the arguments that we have heard are largely driven by those forces. But, something very exciting happened in July of this year. Consumers Report has pulled together what is considered to be the liberal and conservative views of the health care system. It does it in a very thorough way. Speaking as someone who has been working with this issue for a while, the article brings together that kind of information in a very helpful way. We all come from different professions in this room. We all share one issue in that we are all consumers or potential consumers of the health care system. That's the common bond among us and that's what Consumer Reports brings to the debate about health care. It looks at what serves those people who need the care as opposed to what serves those people who deliver and benefit financially from the health care system.

There are two major issues around health care today. One is access. We have approximately 15% of our population, between 1.2 and 1.4 million people, who have no health insurance. That's basically the access issue, but it's just a part of it. A piece of that issue that we haven't looked at very carefully has to do with those people who have some form of coverage, but do not have good access for a variety of reasons. I will come back to that. Cost is the other issue. Ohio is concerned more about access that about cost and that's critical. Let's start with the cost issue, then access and then I'll come back to Ohio's solutions.

The unnecessary costs of health care, at a very conservative estimate, is 205 of our current health care cost. In order to get the cost out of health care that is neither enhancing health care or its delivery, there is one solution; a universal access, single payer system. Let's look at where the costs are. Right now, by the Federal Health Finance Agency's own estimate, we are currently spending in this country about $2500 per person on health care. That's the total of what we are spending in insurance or through your self-insured plan at work. The hidden dollars that all of us spend is used to support the public system of care for those people who have no access. We are spending between half and twice as much as most other countries spend on health care, depending on whether you look at it on the basis of gross national product, or on the basis of per capita cost. There are two countries, two industrialized countries in this entire world, who have no form of universal access and do not guarantee that everyone has some level of access to basic health care services. Do most of you know the two countries? What country besides the United States? Well, it's South Africa. We are in the company of South Africa in having no policy that guarantees access to health care for everyone. Now, we are a country that largely believes in competition and, in some ways, that might be all right. But, the truth is that it has come to the point where those people who have no coverage are costing all of us. The popular

term is cost shifting. We are spending $2500 per capita overall on health care. Some of it hidden, some of it evident. Some of it we pay when we go to the doctor's office and some when we go to the drugstore and buy a prescription. Some of what we pay is hidden in the form of taxes. By the FHFA's own estimates, by the year 2000, given the current rate of health inflation, which is more than double the current inflation rate in this country, we will be spending over $5000 per person for health care. I said that to a business group the other day and said, "What are you all going to do about that, how are you going to afford that?" And they asked back to me, "there will be no health care provided by us at that point, we cannot do it. We cannot do it." We've only got eight years at the rate we are going unless there is a significant change in how the cost of health care is managed in this country. By that time, we will have more than doubled what each one of us currently pays for health care.

An interesting thing happened about a year ago. I addressed a group of social workers. I went in expecting that they would tell me about their clients and their concerns about health care. I was very much taken because they wanted to talk about their own personal situations. They were all employed, but they were also all parents, they had kids. Several had kids that were born with disabilities, or with serious health needs, and they wanted to talk about their own situations. At the end we got around to talking about the concerns of their clients who were what we would call poor. It's a franchise to have less money. That is, I think, the crux of what this issue of Consumers Report is about.

This year, the proposed Ohio Legislation will try to solve the access problem for people who have no insurance. By the time the bill passes the House and then the Senate, it will have gone through thirteen versions. Even for the legislature, that's kind of an astounding number. We are not talking about small revisions, but major revisions. I think the reason for this is that (House Bill 478) is trying to deal with access for people who have no coverage without dealing with cost. The reality is that for most of us who have insurance, myself included, most of us have avoided use of primary health care sometime in the last year. Not because of the cost of that health care of because of not wanting to have it on our records, but because of what it would do to our future ability to change jobs and remain insured. The older most of us get, the more we'll be denied unemployment. Not because we don't have skills, but because of the way insurance companies rates are based on age. I have had health insurance for my entire life, my parents paid for it when I was young. I was paying my dues for a time when I might need an insurance company to cover the cost of health problems. Not because I was selfish and wanted to use the health care system badly, but because it's a natural part of growing older and living with health care problems. The insurance worked well for us when we had what we called community rating. We had a very large group of people, all of them paying essentially the same rate. You paid when you were well. You paid against a time

when you might not be well. Same as the insurance on your house. I don't want to lose my house if it burns down, so I am willing to pay insurance against the possibility that it might. I will pay it all my life, will pay it gladly, and hope my house stands the whole time. I hope my health holds too; my childrens and that of my parents and family. But, that's why we pay insurance. However, what's happened in insurance now is something very different. There was a cartoon in the paper the other day. Someone was applying for health insurance and the agent was saying to them, "You have to sign this statement that you will never get sick, never, and if you do, don't come back and ask me to cover it." Right now, I am spending $300 a month for a family insurance plan. For two years, and I am not proud of this fact, I waited to go for a mammogram. Why didn't I go? Well, I have two adopted children and I'm a single parent. My insurance is their insurance. I am just one employee of my company. So, I am in the small employee market. I am savvy enough to know that if I went and found I had problems, my insurance either would be cancelled or it would be raised to the point where I could no longer afford it. That would be all right if I was taking the risk just for myself, but I have two children that need me. So there are crazy risks that we're living with.

So, access is a bigger issue in Ohio and in this country then cost. Take the testimony before the conference committee on H.B. 478, there has been an enormous debate over genetic testing. I don't know what Representative Jones is going to tell you tonight. He opened the conference committee process to the public, and it's usually a closed process. He opened it and it made a large fuss publicly. I hope the press holds him accountable if he doesn't follow that process through to the end because it's our issue. We have a right to know how the decisions are made. It is all our issue on a cost basis. One solution after another was thrown in H.B. 478. The principle one was the Health Association of America's solution which some of you are probably familiar. It requires all insurance companies to guarantee access for anyone who comes and applies. It was a struggle in this state between Blue Cross and the private insurers. One feature of the bill, according to a Blue Cross study, would have brought 52,000 of the 1.2 million uninsured Ohioans under coverage. But, remember, we're talking about access, coverage and cost. The proposal would have driven up the cost of health insurance for everyone in the state, a cost shifting factor of 8 to 12%, to $250 million. But here's the kicker. It won't insure 52,000 new people for $250 million. Actually, only about 22,000 additional people will have been covered at a cost of $250 million. That proposal dropped out right away and it dropped out because business came back and said, "you told us this was going to help us. We're looking for predictability. We are hoping to cover more of our people. We don't want to have to make choices of who we hire on the basis of age and health status. We want to decide on the basis of qualifications. If it's going to cost us that much, we're not supporting the bill. After that dropped out, there were twelve more solutions, none effective.

There is only one solution currently out there that does not drive up costs. That is the universal single payer plan. It is the only one that will take those unnecessary costs out, spend the same amount that we are spending now and not kick people out of the system. It won't prevent people from getting the treatment they need and it will do some other things as well. One of the things that needs to happen is that people must be able to get what they need without getting too much. Managed care systems are working along that guideline, but they're not dealing with the cost for everyone. Consumers Report says that we are currently spending about 20% of our health care dollar in wasteful ways. We are talking essentials. We are talking about a country that is 21st among industrialized countries with infant mortality. Children must be immunized. Diseases that were gone long ago are coming back. Tuberculosis is rampant in this country again. We're not doing the basic things for the largest number to people in this country. We need to make critical choices, but I think it is possible to make rational choices. Thank you very much.

Our next speaker is Representative Tom Watkins who currently is a representative in the state legislature from the 44th legislative district and has served since 1985. He is a graduate of Kent State University with a B.A. in Government, a graduate of the University of Akron School of Law in December 1991, the author of a basic health care plan in the legislature and the Good Samaritan Plan for health care. So without further, Representative Tom Watkins.

Thanks John. About three years ago, we had a policy committee in the republican caucus in Columbus and we started a program of outreach. We went out across the state and interviewed in seminar form hospitals, doctors, providers of health care services and equipment, and nursing home administrators to try to get a handle on where we thought things ought to be going. Since that time, it's become the focus of national and state attention. I guess it deals predominately in two areas; health care access and affordability. However, it's difficult to discuss one without discussing the other. I would like to take you back to about 1970 in order to demonstrate how we got where we are today. Prior to 1970, the family physician was like the gatekeeper in health care. You went to that family physician for anything and if he or she could not handle your problem, you would be referred to a specialist. In the 1970's the specialist came to the legislature and said, "We want to cut out the middle guy and let people come directly to us. This would provide better access and people would save money because they wouldn't be paying the referral fee to the family physician." This sounded like it made sense so that's the direction we took in Ohio and other states did as well. All of a sudden you saw the change in medical schools. They were no longer producing family physicians, they were producing specialists. This brought about higher costs in the area of medicine, but it did provide for specialty in various areas. Although we have tried to encourage more students to pursue careers as family physicians, last year 95% of the graduates were specialists because that's where

the money is. That is because when you are trying to pay off an $85,000 debt from medical school, you want to go where you can pay it off the quickest. As we reached into the late 70's and early 80's, we then got inundated by other medical providers; the chiropractors, the mental health practitioners, and the drug and alcohol treatment facilities. These professions felt that, if we were going to provide health care in Ohio, we ought to mandate coverage for these services as well. Naturally, nobody would argue that these programs were not important. The problem surfaced, however, when we started adding on more and more mandates. The cost of insurance went up and the little guy couldn't afford to maintain his coverage because he had to buy the cadillac version and had no ability to buy or afford a smaller version. Fortunately, the mandates in Ohio have not been as expensive as they have been nationwide. National surveys have estimated an increase in cost of 25 to 30% as a result of such mandates. In Ohio it can vary depending on the carrier, anywhere from 18 to 25%. I introduced what is called the basic health care program. It is designed to eliminate the state mandates, but not completely. Individuals still have the option of buying coverage that includes state mandates, but they may also buy basic coverage without the mandates. You know when I am out door-to-door talking to constituents, their concern in medical cost is that they are going to lose their home. They're not concerned about the doctor visit for $35 or $25, they're concerned about the operation for $30,000 or $40,000. Therefore, my approach has been, what can we do within the system to restructure some of the priorities and make it more affordable for some people to have health care. Forty percent of those that are uninsured make more than $25,000 a year. I had a guy in my house plastering the walls who had no insurance and a family. He was taking the risk on his own because he could not afford to buy health care. I'm not saying that once you take the mandates out that he would necessarily be able to afford it, but at least it might be a little more affordable. This is where we've got to be a little more creative. What can we do to protect people from losing their homes?

The second area I've looked at is access. How do we get people that don't have insurance access to medical care?

There is a guy in my city by the name of Charlie Casto who used to be the president of the Medical Association. Charlie goes down to Honduras quite often and I dropped him a little note because I have been down there and have seen the devastation of that nation. I said to Charlie, "Why is it that we have to go clear down to Honduras to volunteer our medical services," and Charlie said, "It's very simple, it would cost me $30,000 in malpractice coverage to volunteer my help here in America." That's what prompted the Good Samaritan Bill that I introduced. It would exempt doctors who volunteer their services to free clinics from malpractice. That's what we got to start dealing with, helping these people who need access without costing us a lot of money. I had Charlie do a survey of retired doctors. Out of 600 doctors, 200 were willing to donate four hours a week

to a free clinic. Now that's impressive! If we can try and deal with this within the system that we have, then lets do it. You know there isn't anybody that's denied care in a hospital today and I repeatedly get calls from people, two in the last three years, who have had operations and didn't have insurance. In both cases, the hospitals had indigent funds to cover those expenses. We have a system that works, but it's expensive and we need to get that under control. We need to look at containing the cost of annual increases by using a consumer price index. We should also provide some incentives for those doctors who volunteer services or those who are willing to take patients for free in exchange for tax credits or deductions. There is a lot we can do in America (without using our wallets) if we use our minds and our hearts. I think that is the Republican approach to trying to deal with health care. Health care is important enough to guarantee that everybody has it, but we've got to go at it in a way that is affordable. Every time we pass a bill that costs money, it costs jobs. We've got to be very appreciative of the fact that the small businesses today create most of the jobs and we have to be very protective so that we don't cost the jobs in Ohio and America because a system that's too costly.

Our next speaker on the panel is Representative Wayne Jones, who represents the 43rd District of Ohio in the state legislature. He has represented his District since 1988. Prior to becoming a member of the legislature, he was the Deputy Director of the Ohio Department of Insurance. He presently chairs the House Subcommittee on Health Insurance and he chairs the Joint Conference Committee on H.B. 478 and is Vice-Chairman of the House Insurance Committee. He is the author of the Omnibus Health Care Reform Act. He is also on the Education Committee, chairs the Colleges and Universities Committee, the Financial Institutions Committee, the Public Utilities Committee, and the Health and Retirement Committee. As you can see, he has a very broad background in many aspects of this very complicated problem, so it is my pleasure to introduce Representative Wayne Jones.

It is a pleasure for me to be here this evening to talk about one of my favorite subjects; health care. It is something that I spent literally the last ten years of my life working on in various forms, first at the Department of Insurance and then at the legislative level in Columbus. It is a very difficult issue and you've heard various plans. Everybody's got a plan and I can tell you right now that none of them have simple solutions, none of them are free, none of them will solve all problems, there is no panacea. I would just like to share with you my views on a couple of them. Earlier you heard a representative from U-Ohio, which is the universal health care plan for Ohio. It was put in a Bill by Representative Bob Haggin. Bob is a very good friend of mine, very knowledgeable in the area, and I really like a lot of his bill. It sends a very strong message about health care in Ohio, but there are a few problems that Bob and others who support the bill want to overlook. Number one is cost. We predict that

bill if passed next year would cost (the state of Ohio) somewhere in the range of $34 billion. Now $34 billion in government money is a lot of money when you consider that our state budget is $14 billion. So, we would have to raise all taxes 250% in order to fund the bill. Granted, nobody will have to pay health care premiums and that is a reasonable argument. But, we still would have to fund this through a tax increase of about 250%. Secondarily, there is a federal law called ARESA that has been on the books since 1974. Basically, it exempts self-insurers from state law. In other words if you are self-insured like many large employers are today, you can exempt yourself from state law. So if a large employer does not want to participate in the U-Ohio Plan, it can exempt itself out by a designation to that effect. If everyone that was self-insured did that since approximately 60% of the people presently insured are self-insured, the remaining 40% of us who are traditionally insured would pay for all 1.2 million Ohioans who do not have insurance. So the burden would fall on about 40% of the population. That problem has got to be worked out before we pass the U-Ohio Plan. The other plan that has gotten national attention and has also gotten some state attention is the Pay or Play Plan. While I like that plan a little bit better, I still think that it has a short fall. If in fact employers could afford to provide coverage, it's my view they would because you can get a better employee if you provide coverage. Someone sent me a cartoon. It had a man who was applying for a job and the person who was interviewing him. The interviewer was looking at him and saying, "Obviously with the benefits we offer, there is no salary with the job, you understand that." That is the problem with the Pay or Play Plan.

I am not saying my bill is perfect, but it is a start. It's called the Omnibus Health Care Reform Act, H.B. 478. Unlike the other two bills, it's passed the House of Representatives, it's passed the Senate, and it's now in the Conference Committee on which I am the chair. We are talking about a number of things in the committee and I want to touch on some of the key points. The focus is small business, children and senior citizens. These three groups, I believe, are most at risk and most vulnerable under the present insurance system. I look at small business as those with under 50 employees. Typically, they don't employ a risk manager; they usually don't have a sophisticated buyer; they rely on an agent to tell them what the good, bad and ugly is of an insurance policy. Traditionally, they don't have the large numbers in which to negotiate on their own a reasonable price for an insurance policy. So, they end up with a policy based on whatever the company offers them. It's a one-way contract so to speak. What we try to do in H.B. 478 is say that rates cannot be increased by more than 15%. There would be a rate band on premiums for all people. They would be more community rated to prevent huge fluctuations between the groups as far as the initial rating. Further, the insurance policy would be guaranteed renewable. It could not be canceled under any terms. If someone discovered a pre-existing condition or developed a condition during the policy they could not be excluded. You've seen

that on the AIDS issue. Those who self-insure can just arbitrarily, during the middle of the policy year, determine that the policy benefit level for AIDS, which was $100,000, is now $2500. That's too bad, but the court has upheld it. So, those are the kinds of things we're looking at.

The other issue in small business is with pre-existing conditions. Currently, you apply for insurance and, because you have a heart murmur or because you're a diabetic, they will not insure you for that condition for a least the first twelve months of the policy. That's okay because it prevents adverse selection as with those who wait until they get ill before they go and buy insurance. So I think a 12-month or a 6-month pre-existing condition requirement is reasonable, but a problem occurs if you ever want to leave that insurance company. The next insurer will also require a pre-existing condition limitation. Under H.B. 478, once you've served your time, if you change jobs or change carriers and stay insured, you don't have a gap. No one can ever impose on you another pre-existing condition requirement. These small business reforms have been nationally recognized by a number of groups.

Another area where we are focusing very strongly on is children. You are looking at a person who feels very strongly that we can stop a lot of the health problems by focusing on our children. We have 335,000 uninsured kids in Ohio today. Their only access to the system is usually through the emergency room and that's not the only kind of care kids should receive. If you wait until they get so sick and can't afford to take them to the doctor, you can take them to the emergency room because they won't turn you away. But that child goes without routine checkups, and that child goes without immunizations. It has been proven that only 31% of Ohio's children are properly immunized. That's a disgrace when you realize that one case of rubella cost $354,000 during its life and can be prevented by one shot. It's something that I think society has a duty to prevent and that's what the children's plan is all about in H.B. 478. We are trying to get access for basic inpatient and outpatient preventive care for every child at 200% below poverty. There is another provision in the bill that requires insurance companies to provide children's health care services. Many current plans, if you have children, will not pay for routine office visits. They will only pay if your child is sick. If you take them and they're well, most policies will not reimburse. In my time at the Department of Insurance and my five years chairing the Health Insurance Subcommittee, I've asked every witness before that committee to show me the numbers; show me where mandates cost Ohioans more; convince me that Ohioans should do without maternity benefits and mammography screenings. Show me where that saves money.

I am going to close with just a couple of things about senior citizens. Part of it deals with Medicare balance billing. In our bill, we prohibit providers from balance billing senior citizens who are 600% or under the poverty line. It only

makes sense. Another provision in the bill says that no person, including a senior citizen, shall lose their home or their car or more than 12% of their wages in payment of medical bills. Nobody should be in fear that they are going to lose their home because they got sick. I believe I'll stop on that note. I will be happy to answer you questions as this seminar proceeds and I appreciate you having me. Thank you.

Our next panelist is Cynthia Snyder who's Associate Director of the Department of Legislation of the Ohio State Medical Association. She is a 1984 graduate of Capital University Law School, a member of the Ohio Bar since 1984, and a member of the Health Law Committee of the Ohio State Bar Association. So she brings a varied background to this subject and we welcome you to the panel this evening.

Thank you. My name is Cynthia Snyder. As mentioned, I'm the Associated Director of the Department of Legislation for the Ohio State Medical Association. Essentially, I am a lobbyist. I spend a lot of time in the state house monitoring health care legislation that impacts the practice of medicine in the physician community. For those of you who aren't familiar with the Ohio State Medical Association, we are a professional association representing approximately 15,000 physicians, medical students and residents from around the state. We are affiliated with the American Medical Association and also with county medical societies, Summit County Medical Society, for example. At all three levels, we represent the largest membership organization for physicians. The American College of Physicians is endorsing global budgeting and caps on fees for physicians. They are not us! We do not endorse caps on fees for physicians or global budgeting. We have been active as an organization at both the federal and state level during the ongoing discussions on health care reform. We have been called upon to react to a number of solutions that have been proposed. Our approach to these various reform systems is for the position of the physician as a patient advocate. I will tell you very honestly that sometimes our motives are distrusted and there are those that think some physicians are just out to protect their income. I truly believe, in the vast majority, that is not the case. The physician community views itself as an advocate on behalf of quality, cost effective health care for patients. In response to all the various proposals, the American Medical Association adopted health care proposal of its own called Health Access America. It was formulated at the national level.

Unlike several of the proposals that were discussed this morning, Health Access American builds on the current public/private system. Rather than eliminating private insurance or dramatically narrowing the scope of private insurance, it attempts to build on what we believe are the strengths of our current system. Those strengths include the fact that currently 87% of Americans do have some form of public or private health insurance. The superior quality of

health care service and medical technology that is available is really important to us and I think to you as consumers. Further, the ability to freely choose who provides your care is in the consumer's interest. Health Access America does not seek to maintain the status quo. What it seeks to do, I think, is encourage compromise among all of the interested parties: government providers, physicians, insurance companies, employers and consumers. Just as virtually all of the health care reform proposals out there, Health Access America has sort of two planks: cost containment and increasing access. All proposals approach the problem from those two planks. With regard to access, some of the proposals included in Health Access America are mandated employer coverage of all full-time employees. That one is very contentious. The business community does not like the idea. It calls for reform of the small group insurance market in much the same way as that those reforms are proposed in Representative Jones' H.B. 478, including the pre-existing condition limitations, guaranteed renewability, caps on premium increases and the like.

Health Access America also proposes an expansion in Medicaid to cover everybody who has an income under the federal poverty level. Currently, only 40% of the people who earn less than the federal poverty level qualify for Medicaid. Obviously, there is a big, big dollar sign associated with that particular proposal. We would also call for restructuring Medicare to insure that it is actuality sound. It currently is not. We would encourage the creation of state risk pools for small businesses and individuals to create a larger group and spread the risk. With regard to cost containment, one of the proposals in Health Access America would eliminate the existing state mandated benefits and require the offering of a minimum benefit package. It's not bare bones; it's a bit more comprehensive. The AMA has gone on to define what it thinks constitutes a minimum benefit package. It's not a Cadillac, but it's not a Chevette either. A second class containment proposal would be to control insurance companies and provide administrative costs by developing and using a standard claims form, electronic billing and the like.

Again, that proposal is included in H.B. 478. Another cost containment mechanism that's advocated by Health Access America is the development of practice parameters. Those are a set of protocols or guidelines that would direct the physician in providing care and treatment for a given illness or a given condition. That's designed to minimize unnecessary tests and treatments and to combat the medical malpractice situation. Health Access America also calls for anti-trust protections that would allow providers to discuss openly what their fees and charges are. Currently, under the federal anti-trust law, physicians who discuss publicly their fees or post them or talk with physician colleagues about them, subject themselves to federal anti-trust liability which has a huge penalty attached to it. What we would like to see is some anti-trust protection put in place that would allow you as consumers to go into your physician and ask how much a

procedure is going to cost. This would allow you to make more educated decisions about the providers and the type of health care treatment you seek. The anti-trust protection would also allow us as a physician organization to engage in peer review for fees and pricing policies.

We also would like to see some reforms in the medical malpractice system. Frankly, some of these we have been successful in getting through the state general assembly only to have them struck down by our Supreme Court. But again, in the best of all possible worlds, we would like to see a cap on non-economic damages like pain and suffering. These damages don't have any quantifiable cost associated with them. Alternative dispute resolution and provisions that deter frivolous suits could reduce the costs of those claims.

In conclusion, I would like to say with regard to the ongoing legislative effort in H.B. 478, we compliment Representative Jones and the legislature for tackling a tough issue and we have been more than happy with the access they have afforded us to provide them with our ideas and our reactions to some of the proposals. We look forward to good working relations with the legislature on this issue. Thank you.

Our next panelist is Janet Holloway, Registered Nurse and educator at the Akron Children's Hospital Medical Center, a member of the American Nurses' Association and Ohio Nurse Association Legislative Committee, and chairman of the Summit-Portage District Legislative Committee. Welcome Ms. Holloway.

I want to thank you for inviting a representative from the Ohio Nurses Association to speak. In 1988, a group of nurses decided that we were very upset with health care. We needed to look at where we could help as far as legislation is concerned and educating everyone in the community as well as the political arena on what we felt was necessary. The three key points that we saw were quality of care, access and cost. We feel that nurses who practice in health care provide a very unique perspective to the health care system. Our agenda calls for an increase in preventive care, insurance reform, provider reform, cost containment measures and a great reliance on individuals themselves to be responsible for some of the key elements.

Access for all citizens and residents we feel should be federally defined. It is essential for health care services. We also feel that the consumer needs to have the privilege to choose their provider. We believe also that the consumer involvement is essential to the restructuring of this system. We witness daily problems of access to quality care. In 33 states, nurse practitioners are being reimbursed federally for the care they provide. Nurse practitioners give efficient care, cost effective care and quality as far as preventive medicine and updating the general public. In Ohio, there are some pilot programs going on at the

University of Akron and Children's Hospital. In working collaboratively with doctors, nurses are reimbursed for their services through Medicare. Primary preventive care is the focus of this restructuring. We would hope that the consumer will take an active part in this part of the program. The key features of this proposal offer direct reimbursement for alternate providers of care and reform the current system for the delivery of the health care. The proposal assumes that such reforms are essential for affordable care and primary access.

In order for you to understand what a nurse practitioner does, I need to define her tasks. She does patient education and physical assessments. She also does screening and managing of basic routine health problems; she will counsel, refer, and prescribe medication. Managed care can be arranged and we hope it will reduce the cost of health care. Other than restructuring the health care system, we would hope to phase in other essential services in order to have responsible coverage. For instance, the coverage of a pregnant woman and her child is critical. Therefore, we support the healthy start plan to help improve the health of children. We also hope to implement steps to reduce health care cost through a planned and prudent resource allocation. This could eliminate some of the unnecessary cost. We would like access to services assured by no payment at the point of service and eliminate the balance budget billing in both the public and private plan. This is just a brief summary of our health care agenda.

Thank you very much Nurse Holloway.

Our next speaker this afternoon is really a pleasure to introduce. Dr. Rakich is one of five distinguished professors at the University of Akron. Dr. Rakich has a Bachelor of Arts Degree in Economics and Business from Oakland University in Rochester, Michigan. He has an MBA in Business Administration for St. Louis University. He teaches graduate and undergraduate courses in Strategic Planning, Business Policies, Health Services and Administration. He also has a joint appointment as a professor of Bio-Medical Engineering in the College of Engineering and also as an adjunct fellow in the Institute for Life Span Development and gerontology. It is my great pleasure to introduce Dr. Rakich to you this afternoon.

Thank you very much, it is very nice to be here, I appreciate the invitation. I would like to take just a little time to give you some perspectives. I have been studying health care policy for about twenty years and I still don't understand it. If you asked me how hospitals are reimbursed and how financing occurs, I'd tell you I don't know. It's really complicated. I spent time in Canada in 1989. I received a funding grant from the Canadian government to support my on-site research. I spent time in British Columbia, Ontario and Quebec. Have you ever had a 2000 piece puzzle? Then, you realize the necessity for understanding the Canadian health care system. It was very difficult to put all the pieces together,

but I think I've done it. My focus had to be limited in order to accomplish that. It was limited to the hospital services sector and the physician services sector. I don't know anything about long term care, mental health, or public health. Basically, my focus was the physician services sector and hospital sector, two in terms of expenditures. In 1992, expenditures for health care are projected at eight hundred and nine billion dollars. That represents 13.4% of our gross national product. That means one out of every seven dollars and fifty cents of our total societal wealth is spent on health care. Go back to 1965 with the enactment of Medicare and Medicaid our expenditures were forty-one billion dollars, 5.9% of GNP. We've had a 100% increase in the amount of societal wealth devoted to health care in the United States. One out of every $7.50. If you divide $809 billion on a daily basis, it's 2.2 million dollars a day. That's $91 million dollars an hour. So, for the next forty-five minutes, we'll be spending about 75 million dollars on health care in the United States.

Here are some aggregate numbers that you might be aware of. The Organization for Economic Cooperation Development based in Paris, France conducts economic studies of member countries. These include 24 countries from Europe, North America and the Pacific rim. The organization presents aggregate health care expenditures data for those countries. It is very difficult to determine expenditures by sector because there is no common definitions and there is no commonality in terms of exclusion expenditures. For example, in West Germany, Scandinavia and the U.K., salaries for hospital based physicians are included with the hospital sector. In the United States and in Canada where physicians receive fee for service, they're included in the physician services sector. So, O.E.C.D. focuses on relative comparisons between countries based on gross domestic product and gross national product. Basically, they are similar. O.E.C.D. also indexes per capita expenditures. In 1989, Canada spent 8.7% of its gross domestic product on health care. Australia, Austria, Denmark, Finland, France, West Germany, Greece, and Iceland all spent about 8%. The U.S. spends 11.8% of gross domestic product on health care. The mean average excluding Turkey for all 24 O.E.C.D. countries was 7.6%. We spent 55% more of our societal wealth on health care than the average for all O.E.C.D. countries. Belgium spent only 7.2% gross domestic product on health care. In terms of per capita expenditures, Canada spent $1,600 per capita in 1989 and the U.S. spent $2,300 per capita. The O.E.C.D. average was $1,000. We spent 133% more per capita. I have a wife and two kids, and that's a total of $6,000, round that up to three and that's another $7,000 my family spends on health care in the United States. A lot of dollars. In terms of private financing, the U.S. performance is miserable. In Canada, 74% of aggregate health care expenditures are paid for by the public. In the U.S., 41% of all health care expenditures are paid for by public sources. Look at the other countries. The O.E.C.D. average is 75%.

So, what's the Canadian model? The Canadian model is called Medicare. The crown jewel of their social program. It is a very social oriented country. It took me a long time to figure out where things fit. They have the social democrats, the conservatives and the progressive party. All three parties are to the left of our democratic party. Canada is a socially conscious country. Canadian Medicare consists of a set of provincial and territorial plans that, taken together, form their health insurance system. There are ten provinces and two territories. Yukon has a total population of 25,000. The Northwest territory has a population of 50,000. Ontario has a population of nine million, approximately the same as Ohio. Quebec, the second largest province, has a population of six million. What is the Canadian model? It is a set of provincial and territorial health insurance plans for the ten provinces and two territories. It is comprehensive and universal. It is publicly funded and privately delivered. All of Canada's 26 billion residents receive health care from this insurance program with the exception of certain segments, the military and native peoples which are federal responsibilities. It is not a national program, it is not a socialized medicine. Ninety percent of 1200 hospitals are public hospitals, they are not government homes. Almost all of the licensed independent practitioners are in business for private service, they are not government employees. There is no financial access barrier here. There are no low payments, there are no deductibles. There is free choice. People may choose whatever provider they wish. There is a gatekeeping system though. To get a specialist, you've got to go through a general practitioner.

The primary difference between Canadian and U.S. health care is the way in which it's financed. The U.S. is not universal or comprehensive. It is not publicly funded except for the thirty-two million Medicare beneficiaries and the 21 million Medicaid beneficiaries. But even for them, there are direct co-payment deductibles, premiums and need tests that create access barriers. For the 182 million people in the United States who have private health insurance, 82% of them receive it from their employers. Coverage for them is patch work, it ranges from full and comprehensive to limited and minimal. The financial risk basically rests with co-payments, deductibles, limits, and those sorts of things. Thirteen percent of our population, 37 million people, have no insurance and, I don't know the number, but many more are under insured. In Canada, the forty year revolution of health care has been largely induced by ten provinces that had hospital insurance programs. In 1961, Saskatchewan was the leader; initiating medical care and physician service plans for the province. In the United States, the basic enabling legislation is Medicare and Medicaid that were created in social security. In Canada, there are basically four major pieces of legislation related to health care. First, in 1957, was the Hospital Insurance Services Diagnostic Act. It basically said that the federal government would pay 25% per capita costs nationwide and 25% of provincial per capita cost. Initially, it only included inpatient services, but it has subsequently added outpatient services. In 1966, the Medical Care Act was passed to provide physician services. The federal fiscal responsibility at the time

was 50% of the per capita expenditures nationwide. In 1977, Canada realized this and amended those two provisions in terms of financing. It repealed the Hospital Insurance Diagnostic Services Act and the Medical Care Act. It basically changed the 50% federal fiscal responsibility to 25%. Then, the federal government transferred tax points and also made transfer payments to provinces, essentially making it a fiscal responsibility of the province. Basically it did three things. It capped the federal fiscal responsibility. Next, it forced the provinces to pay for the care with taxed. The high visibility of taxes made the government accountable to the public and forced an end to discrimination between high paying and low paying provinces in terms of health care. Under the Hall Commission, the physicians were able bill extra and hospitals were able to demand user charges for services rendered. Then, the Canadian Health Care Act of 1984 which constitutes the current legislation. It bans user charges and extra billing. This just does not exist. It also says, to receive federal funds, the provinces have to offer universal comprehensive coverage and there must be public administration. So, when we think of Canada, think of it as one great big HMO. A macro HMO. In fact, that is what it is.

In Canada, there are 26 million people in the whole country. There are more people in California than in Canada, Michigan and Ohio, add them together, it's about the same in terms of population. Canada's population is 25 million, the U.S. population is 26 million. Canada's gross national product is 400 billion. We've got four trillion in the U.S. The percentage of population age 65 and over is approximately the same, 11 and 12 percent. The number of people uninsured in Canada is zero. . . . . zero. The number in the U.S. is 32 million. Recent numbers make it 37 million. In terms of number of physicians, there are 55,000 in Canada, 600,000 plus in the United States. Hospitals total 1,200 in Canada. There are 6,800 in the U.S. If we look at some other indicators, we see the total number of beds in Canada for a population of 1000 is 7.1. Some of those beds are for long term care and, interestingly, in a competitive strategy here in changing inpatient care beds to long term care beds. Makes a lot sense. In terms of occupancy rate, it's 83% in Canada and approximately 68% in the U.S. Health care expenditures equal 40 billion in Canada and 600 billion plus in the U.S. If we look at occupancy rates for short term hospitals in the United States compared to a similar group in Canada, which is actually term care, we see higher occupancy rates in Canada. This is because patients have longer stays in Canada. The cost per day for each patient is $243 in Canada and $500 in the U.S., basically doubled. Canada is one-tenth the size of the United States and basically functions as a macro HMO. In terms of other attributes, delivery is private in the U.S. and it's private in Canada. It is not socialized medicine, it's private delivery. In terms of coverage, Canada has universal, comprehensive coverage. In the U.S., it is all over the map. We've got Medicare, Medicaid, managed care, self-insured employers, self-insured and uninsured individuals, Blue Cross, Blue Shield; it's really a quilt, it is patch work, a mosaic that's very difficult to put together.

What about financial barriers? There are none in Canada, it's complete access. In the U.S., there are many barriers. The deductible on my policy increased by $500 per year; that's a financial access barrier. Tax rates are very high is Canada. The income tax report in Canada is one page, no deductibles, nothing. Right off the top, you're talking 50% of income or more. Tax rates are very, very high in Canada. But, the people are willing to pay for their social program. That has come through loud and clear, they're willing to pay.

In the U.S., we're not willing. In fact, we have interest groups who are unwilling. For example, in 1988, the Medicare Catastrophic Health Care Act was repealed simply because that segment of the population that was going to benefit from the program the most was unwilling to bear the full financial burden. The payer model is single payer, one payer. In Canada, provincial ministry of health is the United States. Some of the discussion earlier was about administrative cost. In 1991, a general accounting office study said that a single payer system in the United States would probably create savings of approximately 60 billion dollars. That's no small piece of change. Canada's focus of control is centralized to single payers. The provincial ministries of health the bills, that's it. They have absolute control over the way the resources are distributed within their province. In the United States, it's fragmented. Cost control is very high in Canada, very low and fragmented in the United States.

Capacity is also highly controlled in Canada. The provincial ministries of health determine which hospitals may add new beds, new programs, and advanced technology. If the provincial ministry of health does not approve a request, the funds are not distributed. Real simple. Hospitals have perspective global budgets. The ministries of health set a global budget expenditure for hospital services in the province and then divide it up among the hospitals. Quebec and Ontario have very complicated distribution systems. Basically, provincial ministries of health will only increase the budget for increased volume and new programs that are approved. But, whatever the global budget is for the hospital, unless they seek further, that's it. That's all they get, they can't deficit spend. Hospital must service all who present themselves. It creates a sector global budget and specific hospital budget. Hospitals are not volume driven. In fact, they have the opposite incentive, they don't like volume.

In the United States, the opposite is true. We like more occupancy, it is volume driven. In Canada, there is low competition. In the United States, there is great competition for customers. Accordingly, we have seen high casualty rates. Over the last six or seven years, approximately 100 hospitals closed. In Canada, physicians are paid fees for services. The fees are negotiated as in Belgium. The medical association in the province negotiates with the provincial minister of health and they set fees and that's it! In each province, a global sector fee is set and an aggregate expenditure is set. Five provinces, representing 80% of the

population, have recapturing provisions for volume increases that exceed or approach the threshold for the aggregate sector budget. They discount the fees. In Quebec, the only province to do it, they limit physician income. It's thirty thousand dollars quarterly. If the physician billing exceeds thirty thousand in any given quarter, subsequent service is only paid 25% of the fees. Reimbursement of hospitals in Canada is also closed. It's a fixed budget as well. In the U.S., it is open-ended. The incentives in Canada favor low admission. In the United States, we have incentives for high admission and incentives for cost shifting. There is no incentive for cost shifting in Canada. This is because there are no multi-institutional systems.

We have many systems in the U.S. But, Canada has some problems, one of which is the infusion of advanced technology. Canada controls its health care cost by controlling capacity. I think that if you restrict and control capacity, you also control utilization. In Canada, in 1989 data, they had 39 cardiac units and 37 open heart surgery units, approximately 800,000 people per unit. In the United States, we have 791 total, 300,000 people per unit. We have triple. Canada, I'm told, has twelve MRI's. I am told that there are more MRI's in the Cleveland area than the whole country of Canada. So, Canada's macro resource commitment for health care is basically close-ended. It's capped, heavily influenced by government budgets, price setting mechanisms, and the high visibility of tax sources and funds used to finance the system. The commitment is essentially capped by using an index to GNP. The provincial resource commitment is perspectively budgeted for hospital sector expenditures and, in the physician sector, fee schedules are perspectively set and modified in a number of provinces.

In contrast, the resource commitment in the U.S. is open ended. There is no limit and there is no system of volume control, none! Capacity planning and resource distribution in Canada are centralized. Provincial governments set global budgets for hospitals and, through that mechanism, control new beds, new programs, and advanced technology. Consequently, the single source payer model with sector budgeting enables great control over the systems capacity that is supplied with distribution costs. Capacity control and resource distribution in the United States is virtually nonexistent, except for regulations and certificate of need programs in thirty-nine states. The control mechanisms that presently exist in the United States do not correctly affect capacity, resource distribution or the addition of new technology. Price control mechanisms, such as rate setting, have not worked. The application of the 1992 physician payment reimbursement system for Medicare beneficiaries based on resource relative values is a step in the right direction. However, our new payment scheme, which was implemented this year and has a five year phase in period, has no volume control and no aggregate sector cap.

What about limits? Does Canada have limits, yes. Does the United States have limits, yes. Limits in Canada are based on capacity medical priority; highly visible and subject to a little debate. In the U.S., there are a few capacity constraints. Limits are based on the ability to pay. Those who are uninsured or under-insured are less visible, and these selective segments of the population have relatively little political power. Will the Canadian model work here? I answer no. Publicly funded, universal, comprehensive health insurance appears to work very well in Canada. Will it work here? Two riders, Endovan and Cronic indicate that it will not. Any serious attempt to reproduce the Canadian model would provoke the intense and concerted opposition of powerful groups. These two riders stipulated that it would be too radical a change to be politically feasible. Deficit spending and defending powerful interest groups is something that Congress does well. Given the lack of political resolve and the absence of wide spread discontent in our population, why should we assume that Congress will do something? These special interest groups include the hospitals, the providers and the whole private insurance industry. Essentially, all delivery systems.

Another point, would the United States tax itself as in Canada to finance universal health care insurance? Recent experience with the repeal of the Medicare Catastrophic Health Care Insurance Act would indicate that the answer is no. In that instance, citizens who benefited the most were unwilling to pay the cost. Beyond this issue, the political influence of special interest groups is different in Canada. The U.S. emphasis on individualism and mistrust of government contrast sharply with the Canadian of government acting as its agent. U.S. culture is heavily influenced by the competitive ethic. People are individually responsible for their own fame and fortune, and their own health. Government as an industry restricts individualism and therefore not an instrument of first resort. There are some supplemental exceptions such as Medicare, Medicaid, and education. However, the citizenry, in my opinion, is unwilling to grant sole source, single payer power to government.

Finally, U.S. citizens are short term. This has developed in our culture. Our citizens are unwilling to wait or give up anything, especially our demand access to high-tech care. I think there are two reasons why Canada's system will not work here. One is system size. Canada is much smaller. Next, and probably more important, is our culture. I think that we as a society have not yet recognized our responsibility to those who are uninsured and under-insured. There is political debate about it. Clinton's proposing a pay and play program. Bush is proposing is tax credits and tax deductions. In effect, all the health care premiums paid by employers would be taxed, a back-door revenue. Can I take a few minutes for questions? I appreciate your time and your attention. It was really nice to be here.

Yes Sir. You indicated that we're not ready to do very much but as the costs increase there will be more pressure.

I agree with you. We should put some of the financial burden on those who can pay and, when it comes out of my pocket, I will be more judicious in the way I select services and the amount of services I choose. In the '60's and '70's, there was one coverage pay, no deductibles, no co-pay and no premiums paid by employers. This put us into a situation where we have a high demand for health care. Some financial burden has to go on the public. I have personally become much more sensitive to the uninsured and the under-insured, having spent time in Canada. Canadian health care works in Canada. It really works. The public is willing to pay for it and they benefit from it. I'm not quite sure we're ready yet. Maybe we have to change our attitude.

Our next speaker is Martin Hauser. Martin is a life long resident of the Akron area. He has attended both the Western Reserve Academy and the University of Akron. He began his career as a management trainee at the Firestone Bank of Akron. When he left there in 1980, he took a position at Akron City Hospital. He was named Director of Patient Account Services in 1982. In 1987, Martin received his Masters Degree in Business Administration from the University of Akron with a concentration in management. That same year, he was named Director of the Alternative Delivery Systems for the Akron City Hospital. With the merger of Akron City and St. Thomas into Summa Health System in 1989, Martin was named Vice-President of Managed Care. In this position, Martin is responsible for coordinating all managed education, negotiation, and contract maintenance. In addition to his duties with Summa, Martin has served as President of Akron City Health System, ACHS, a non-profit joint venture between Summa Health System and 340 local physicians since its inception in 1988. ACHS is responsible for management care programs such as HMO's, PPO's and most recently has developed an innovative managed care program for the two largest local employers. I turn the program over to Martie Hauser.

Thank you.

I would like to walk you through a little bit of the history of the development and evolution of managed care and also discuss some of the key concepts of managed care; comparing and contrasting it with the traditional indemnity system.

I certainly hope and anticipate that some of you will disagree, hopefully not violently disagree, but disagree with some of the things I'm about to say. Let me start by saying all of us have a horizontal and vertical view of health care. The vertical view of health care is my position when I am standing here. The

horizontal view of health care is what I say when I am laying in a hospital bed saying, "Please do something, anything, whatever it takes, just make me feel better." If we were to take my three children, age 10, 8 and 5 and put them in a room and ask them to design a health care system, I can assure you that they would not design a system of health care that ties insurance for the family to one member of the family and their job and if that member of the family loses or changes jobs, they lose their insurance. That forces individuals to maintain a relationship with their employer that they really don't want, but they have to keep it or otherwise they would lose their health insurance. My kids certainly wouldn't design a system that would encourage the patient to access as much as they want, as often as they want, where ever they want, without having any responsibility. I call that the blank check concept. I would hope that they wouldn't design a system that would allow an individual to lose absolutely everything they have before somebody steps in to offer help. And, I certainly hope that they would not design a system that prevents people from getting health care because they're a bad risk. I don't think my children would design a system that would allow the largest purchaser of health care, the federal government, to arbitrarily set its own payment levels for those services to hospitals at rates that are below what it actually costs the hospital to provide the care, thus encouraging the hospital to shift the cost of that care to other folks. And, I don't think they would design a system that creates incentives for the providers of care; i.e., physicians to specialize in high tech that pays huge amounts of money and discourages them from becoming primary care physicians. I'm giving my kids a lot of credit, but I don't think they would design such a system. Yet, that's the system we have today.

The question is how did we get to this point? Well, there are lots of reasons. I tend to focus on three. One is that we as Americans view health care as an inalienable right, something we are all entitled. I always love talking to consumer groups because they talk about health insurance. You won't hear me talk about health insurance because I don't view what we have as health insurance. If I was to ask you to define insurance, you would probably tell me it is something you buy as protection against catastrophic loss; your car insurance, your homeowners insurance, your life insurance. I don't view health care as an insurance, we call it insurance, but it's not insurance because we don't expect it to cover only catastrophic losses, we expect and demand that it cover just about everything.

The second reason why we have gotten to this point is because we see health care as an unlimited resource. Our demand for health care is only exceeded by the providers ability to supply it. The third reason is that we have unlimited accountability and responsibility. Lets look at the cost in health care that is associated with the following health care issues in society: poverty, drug and alcohol abuse, smoking, poor dietary habits, the amount of stress in our lives, violence and abuse. I apologize to any NRA members, but wouldn't you like to

quantify the cost of health care associated with gunshot wounds that come into the emergency rooms of hospitals because we, as a society, have chosen not to address that issue. Wouldn't you love to quantify the amount of health care costs that are associated with stabbings, beatings, and knifings among families and spouses because we as a society choose to tolerate such abuse. Now obviously, I'm not trying to blame these things and not saying these are the only reasons for health care costs, but some of our other countries that have nationalized health care plans, either will not tolerate some of their things or they will take steps to address the issues.

Let's talk very quickly about some of the societal issues that are affecting health care cost. One of them is consumer expectation and demand. Let me address that from a perspective that I can identify with, my car. I absolutely hate cars. I know where to put the gas and I occasionally wash it by driving through the gas station, but the thing I know about my car is, if I don't occasionally change the oil, the engine is going to blow. I know that if I got into my seven year old car today and hadn't changed the oil in the last two years, I would likely blow the engine. If I blew the engine, it would be a little presumptuous of me to blame someone else for my inability to take care of my car. Secondly, I certainly wouldn't expect or demand that my insurance company pay for my ignorance and lack of concern about the well being of my car. Yet, we as consumers, all treat our cars better than we treat ourselves. We run ourselves at a rapid pace, poor diet habits, smoking, drinking you name it. But, when something goes wrong, we as consumers and as a society expect somebody else to pay for it. More importantly we expect the hospitals and doctors to give us a quick fix to make it all better.

I think the difference between the American system and the Canadian system is that American consumer expectations are significantly greater, as is their lack of responsibility. It frequently amazes me as I travel around and talk about managed care, because of am an advocate of managed care, that I can go to Boston and get a gall bladder surgery and the whole cost may be $2500. I come to Ohio, it may cost $1800. I go to the West Coast, it may be $1800. When you look at the outcomes and the procedure, the training and the people, they all train at the same medical school, they're all classmates, and yet there is no standard protocol throughout the country for various medical services. This is coupled with the fact that there are so many payers, whether they are private payers, employers, government payers, or Blue Cross insurers; everyone has their own forms, their own protocol. There is a tremendous administrative burden placed on hospitals and providers just to comply with all the paper work and forms that the federal government and everybody else requires. I am not criticizing it, I'm saying that it's a cost that we, as society, have chosen to absorb and accept.

In the last three months, Consumers Report has had a series of articles addressing the health care issue. Overall, I thought that they were pretty well done. But, one of the things they talked about was the 800 billion plus in expenditures. They said that out of the 800 billion about 163 billion is devoted to administrative expenses related to paper work, the computer work and everything that has nothing to do with the delivery of care. Of that 163 billion, it has been estimated that 70 billion of it is wasted. So, put that at the back of your mind, 70 billion. Out of the remaining 650 billion plus that was actually expended on health care, it is estimated that about 20%, or 130 billion, was wasted due to unnecessary testing and duplicate testing. If you add the 130 billion to the 70 billion, you have 200 billion out of the 800 billion estimated as waste. That would take care of a whole lot of uninsured and poverty stricken people. But, we in society have chosen not to do that.

Technology is my favorite subject, but I'm not going to spend a lot of time on it. We in the United States have, I call, a techno-frenzy. We race as fast as we can to produce as much as we can in technology for the medical-industrial complex instead of the military-industrial complex. What we do with that technology is put it out on the market place and a year later, we start thinking about how we are going to use it. We start thinking about who should get it, when should it be used and who's going to pay for it. So, we develop it first, then we worry about what we are going to do with it later. We create all kinds of incentives for the drug companies and manufacturers to do that. In business and industry, when a new technology comes on the market, they junk the old technology and use the new. Not in medical care, we use both and usually get both. That is something that is different, but it is something that we tolerate.

I love it when we talk about health care competition because people, especially university folks and business people, talk about competition in terms of economics. I have some bad news for you. We really don't have economic competition in health care. We have new toy competition. We have competition to get out there and buy the newest and latest toys so we can attract the doctors who will bring us the patients.

So, I guess the question is whether managed care is the answer. Well, some people view managed care as the industrial revolution of health care because it brings the administrative and organizational efficiencies of business and industry to health care. Some people say it creates economic competition, not simply competition among systems of providers. And, it does create the beginning of a system actually designed to measure outcome. The only thing that I want you to remember is that managed care should be viewed as a philosophy, not a process. Let me repeat that, a philosophy, not a process. Too often, the critics of managed care are addressing the process. Think about it as a philosophy of care, not a process.

Quickly, let me run through the evolution of managed care. Actually managed care is making a strange evolution. Think back to the old country doctor, the guy who came out to the house and took care of mom and dad and the kids. Those are the kinds of folks that are really going to be the key. We in society are just starting to recognize that we have a shortage of those people. They are called primary care physicians or family physicians. In fact, Time Magazine had a major article about the lack or shortage of primary care physicians and the incentives that we have created to keep people out of primary care and directing them to high-tech specialties.

The next big step was pre-paid health care which is optimized by our friend, Henry Kaiser of Kaiser Permanente, Kaiser Health Plan. It started back in the 1930's and '40's when Henry Kaiser had a novel idea. He thought, why in the world should we pay for people having to get sick. Why don't we create a system that will keep people healthy? So, when he was building the Grand Coulee Dam and had steel mills and ship yards, he began the process of paying doctors a flat fee prospectively to keep his employees and their families healthy. The Hospital Association and the Medical Association said, "we don't like this and we're going to keep him from expanding his practice, we're not going to allow his doctors to get privileges at our hospitals "we can take care of this." So they basically black balled Henry Kaiser the Kaiser doctors. But, Henry was not a fool, he was rich. He believed in the golden rule, "He who has the gold makes the rule," so Henry went out and built his own hospitals. So, what we have today is Kaiser Permanente, a result impart from the medical industrial complex's attempt to keep Henry Kaiser from succeeding. Kaiser Permanente, today, is a model program.

Last time we had a major upheaval over health care was in 1973 when President Nixon decided to push through his administration the HMO Act. The key provision of the Act was that any employer of over one hundred employees had to offer an HMO offer. That's called a mandate. The fact of the matter is that there was an attempt to get HMO to grow in the 1970's. Alternative delivery systems came into vogue in late 70's, early 80's and those were PPO's and all the various organizations. My title was originally Director of Alternative Delivery Systems. Fortunately, that was short-lived, but I got tired of people asking me what I did. The concept of managed care has grown during the '80's through HMO's and PPO's. Actually, as we move into the '90's, there are new words used because the words managed care makes the hair stand up on people's necks. Nobody likes to be managed, especially when it comes to health care. So, president Bush, in a speech to a group of managed care executives coined the phrase "coordinated care." So, now you can talk about coordinated care.

The traditional delivery system, the system we now have that we all grew up with is based on a very simple equation. It says an increased resource uti-

lization leads to better outcomes. If you have better outcomes, you have to have better quality. So the real simple equation is that more equals better. The more you use the better, the better off we'll all be. Managed care equation might look something like this. More resource utilization may not lead to a better outcome, but it may lead to less quality. We do know, however, that it will lead to higher costs and, more does not necessarily perhaps equal better.

Let's talk about managed care. What I would like to do is look at managed care from a non-financial definition and a non-process definition and talk about it as a philosophy being a system. It's a system of delivering health care in which the three entities of health care; the patient, the provider and the payor are working in concert, are working together with the best interest of the patient's health care in mind. The objective is to provide not only medically necessary health care, but most appropriate health care in the most appropriate setting and in a cost effective manner. Without going into a lot of detail, let me just run through some of the various types of managed care programs.

First, the key characteristics of the preferred provider organization. Normally, a fee for service arrangement may include a discount. There is a designated panel of providers organized into a directory. Every doctor that is willing to sign into the program is listed. Then, you can go to any doctor you want; you can go to a specialist or a primary care physician. As long as you go to a designated physician, you get enhanced benefit coverage. If you don't go to a listed physician, you pay a few more dollars out of the pocket. Usually, in a PPO, there is some type of utilization review process. There are incentives for you to use those preferred providers. For example, PPO regulations are limited at the state and federal level. Anyone can organize a PPO. There really is no real regulation. With an HMO, fees are normally prepaid. You pay a fixed fee in advance. Usually, if you select an HMO, you must receive your care through the HMO. So, providers usually pay on some type of fixed fee arrangement and, unlike PPO's, they are highly regulated. They are highly regulated because the commissioners have focused on passing insolvency regulations to protect HMO's from going to insolvent.

At SUMMA, we are beginning to look at developing an insured product through an HMO and it is indeed a cumbersome process. It involves part of the Ohio Revised Code. There has not been a new license for an HMO issued in Ohio in the last five years and the existing regulations and policies are really vague and unclear. In any event, critics of managed care say that the HMO industry is dying. Well, this is the growth chart of the HMO enrollment between December, 1983 and January, 1992. In fact, there are about 40 million people in the United States right now enrolled in HMO's and it's still growing. So, I don't believe that HMO's will go away. In fact, they will probably be the next step, but not the final step. Just bear that in mind, HMO's are the next step in terms of

addressing the concept of coordinated care. They are not the final step, there will be some changes made.

One of those changes has already begun. It is called the point of service plan. It's an open ended HMO. It is licensed as an HMO, but you can go out of panel. Accordingly, it has some of the benefits of a PPO; a kind of hybrid. The reason the model was developed was because the HMO industry was really ahead of the employers and business industry in terms of directing people to providers. Most employers are still reluctant to direct their employees to a group or panel of providers that may result in some employee dissatisfaction. But, I think that the managed coordinated care approach is an evolution, not a revolution.

As you move along this continuum, you will see that we, as a society, have a lot of choices to make. In 1984, over 85% of the people in the United States were in a fee for service plan, less than 2% were in HMO's. As predicted for 1996, less than 10% of the people in the United States will have a standard or typical indemnity program. So, many people are going into the managed care programs. I believe that employers, consumers, and the federal government and insurers and purchasers of health care will continue looking for efficient provider systems that will implement selective contracting strategies. The only way you can accomplish this is through a managed care system. We've polled about 650 employers in the Summit County area. Most of the employers in Summit County are right now implementing cost shifting, cost sharing and maybe some PPO's. Very few employers are really pushing for the next step. But, Summit County has the tendency to drag a little behind. A sound managed care program that focuses on preventive care, keeping people happy and educating the consumer will result in higher quality of care and cost efficiency, if you focus on appropriate utilization, providing the care that is necessary, eliminating duplicate testing, eliminating duplicate costs. Are there any questions, comments, disagreements.

Yes sir. Throughout your conversation, you talked about the primary care serving two purposes. Can you see the consumer losing control of their destiny in the decision making process?

Great question. Let me address it in a couple of ways. Let me go back to my car analogy. I don't know anything about cars but I have a mechanic out here on East Market Street that knows I hate cars, he knows I don't take care of my car, he knows how I drive my car and he knows that since I don't know anything about cars that I occasionally bring it in for service. Last year, I had a transmission problem. He said, "Martie I know how you drive your car and I know what the problem is but I can't take care of it. But, I do know a guy that can handle your problem. He can do it effectively, efficiently and for a lower price than the dealer." To me, that epitomizes what I call primary care case management. Just apply this concept to a physician. I have a primary care

physician who knows my habits, he knows my eating habits, he knows my history, he knows my family history, and he knows how I take care of myself. Now, when I get sick, he is going to know based on my background who best in the medical community can take care of me. Expanding that one step further, looking especially at orthopedics, most consumers on the street assume an orthopedist is a bone doctor. But they pride themselves on specializing; they specialize on wrists, the shoulder, the back, the knee, or the hip, whatever. So, in the traditional system, I have free choice, but my choice may not be the best doctor for what ails me. So, I feel that we all need a physician who can help us become more proactive, not less active, in communicating our decision and our needs for health care.

Our next speaker is Jane F. Mahowald. Jane Mahowald is the Executive Director of the Ohio League for Nursing and a Doctoral Candidate in Higher Education Administration at Kent State University. She is the current chair of the Ohio Council on Nursing. S he is an active member of several national and regional nursing organizations; including, the National League for Nursing, The American Nurses Association, Segmi Phata Tal, the Greater Cleveland Nursing Round Table, the Nursing Committee of the Greater Cleveland Hospital Association and is a participant on the Commission for Health Care Concerns and Federation for Community Planning. Jane Mahowald is going to be addressing the nursing perspective.

Thank you. It is a pleasure to be here and it is extremely wonderful that nurses were invited to participate in this discuss ion.

America's health care system is excellent in many ways. You've heard a lot of negatives about the health care systems today, but in many ways Americans reap the benefits of technological excellence, a wealth of educated professionals, and high quality facilities. Millions of Americans live longer and better because of the health care they receive. Now, having said that, we realize t hat the American system, often called the non-system, is costly, the quality is often inconsistent, and the benefits are unequally distributed. Although the system provides highly sophisticated care to many, there are millions of Americans, that must overcome enormous obstacles to get even the most elementary services.

Responsible for providing care and coordinating health care systems twenty-four hours a day, nurses understand the implications of a failing system. There are more than two million nurses in America; in hospitals, nursing homes, schools, home health agencies, work places, community clinics and deed managed care programs. Nurses see the alarming effects of a system that has lost touch with the many that it is supposed to serve. Too many Americans receive treatment too late because they live in areas where service levels are inadequate. Nurses also see people enter hospitals in advanced stages of illness, suffering

from problems that could have been treated in less costly settings or avoided all together with adequate disease prevention and health promotion services. Disease prevention and health promotion is a primary core of the knowledge taught in schools of nursing today. The lack of access to prenatal care attributes to an alarming number of infant deaths and low birth rates each year. Nurses see a disproportionate amount of resources used for medical intervention that, too often, provide neither comfort nor care. Every year expensive nursing home care impoverishes a large number of residents and their families.

There are four things that nursing, as a community, looked at when formulating its agenda; escalating costs, access limitation, questionable quality and environmental concerns. Let's talk first about escalating costs. As you can see by the first slide, the cost of medical care is the public's major concern over health care. The cost of medical care is, perceived as one of the most serious problems. Along with drug abuse, budget deficits, crime and unemployment. Far and away, the cost of medical care is stamped above the rest. You have heard that the health care cost was 12% of the gross national product in October of 1991, 13.4% in April of 1992, and is expected to reach 15% of the gross national product by the year 2000. We spend more per capita than any other country and yet our infant mortality rate is ranked 21st from the top. We are 17th in male life expectancy and 60th in female life expectancy. Not a very good picture.

Doctor Barbara Starfield, John Hopkins School of Public Health, has compared the United States with nine industrialized European nations in three areas: the availability of high quality primary care, public health indicators such as infant mortality and life expectancy and overhaul public satisfaction with the value of health care. In all three areas, the United States ranked at or near the bottom. In addition, health spending for individuals has rapidly increased at an alarming rate. In 1989, individual spending was approximately $2000 and it will go up very soon to $3000 or more. Health spending as a percentage of pre-tax corporate profits has been astronomical and it is a growing burden on companies. Employers have done everything they can do to shift costs to the employees and that's why the public is the one that is screaming the loudest about the cost of health care. You and I are beginning to feel the squeeze. The amount that we are spending is increasing. What do employers pay for? They pay for hospital care, surgical coverage, employee contributions, and annual employee out of pocket expenses. From 1985 to 1990 the employer's contribution has been decreasing and what the employee pays is increasing.

The next area that nurses have looked at is access limitations. There are growths of equity in medical care but, in general, there are serious access problems. You have heard that 60 million Americans are either under insured or uninsured. A survey of middle class workers indicated that 35% of them would have liked to change jobs but did not because of the fear of losing health

insurance due to pre-existing conditions. It does not seem as though insurance companies wish to insure only the healthy. Another survey done in 1988 indicated that nearly half of the individuals with no access to health care are children. And again, a survey done in Beverly Hills indicated that Beverly Hills had one internist for every 566 people while Compton, a poor Los Angeles community, had one internist for 19,422.

This creates a quality issue which is the third area that nursing looked at. The large percentage of unnecessary medical procedures that are performed in American include tonsillectomies, hysterectomies, lamanectomies, hemorrhoidectomies, etc. Some estimates say that unnecessary hysterectomies range as high as perhaps 50% of the total. I want to tell you a little bit about the use of computerized demography and magnetic resisnots imaging scans, CT and MRI's. They are two expensive, relatively new imagining technologies and they have grown by leaps and bounds yet no one has defined when they are useful and when they are a waste of money. One physician has said, diagnostic imagining is a prime example of how we have continued to invest in technology in an absolutely irrational way. That illustrates some of the comments that have been made about how technology controls health care.

Generally, when you hire an architect or a lawyer, you know what they need, roughly what it will cost, and what kind of services you can expect. But, in medicine, physicians make virtually all the decisions that determine the cost and care. The patient is ill and uninformed. You're in the vertical position and you want them to do anything to make you feel better. The physician is motivated to help you and you are motivated because you have insurance that will cover practically anything. That is the law of induced demand. The creation of medical needs by those who profit from it. Now, many of those physicians do those things because they want to give you the best kind of service, but we as consumers do not step in and say, "Hey, do we really need this?"

The phenomena of induced demand also applies to hospitals. A physician by the name of John Wentworth at Dartsmouth Medical School was curious as to why people in Boston went to a hospital more frequently than people in New Haven. He found that Boston had more hospital beds per capita. Physicians were unaware of the discrepancy, yet 85% of the beds in both Boston and New Haven were always filled. The explanation, John Wentworth believes is that physicians unconsciously refer patients to hospitals based on the amount of beds available. So, borderline conditions that may or may not need hospitalization always end up in the hospital. This drives up the cost of care.

Some of you may be aware of the results of the research done by the Rand Corporation in the late '70's and early '80's. The Rand Corporation used an elaborate process to develop consensus among nationally recognized medical experts.

They formulated and agreed upon a list of indications for various procedures. Then, they checked the actual medical records of thousands of patients who had received the procedure to see whether they had been treatment appropriately. The definition of appropriate was based on the patient's condition, expert opinion and the likely benefit of the procedure was greater than the risk of whether not doing it. They divided the cases into three groups; appropriate, inappropriate and equivocal. Even allowing for the uncertainty, they found that 1300 elderly patients who had and artery operation, 32% did not need the surgery. Out of 386 heart by-pass operations surveyed, 14% were done unnecessarily. Up to 35% of hospital admissions are unnecessary.

Further, the use of the second opinion has come into being as part of managed care. It is required by some and good to have in other cases. Let me tell my experience with second opinions. My insurance required that I have a second opinion. So, I looked around for a physician who could give me a second opinion. The physician that I went to gave me several names and I chose one fellow. I made an appointment and went to see this physician. I told him I needed a second opinion. I had been ready for him to give me an examination. He said, "It will not be necessary to examine you." He said, "Just sit here and let me ask you some questions." So, he asked me some questions and since, I did not want to have another exam I let him go ahead. He asked me some questions, filled in the form and sent it to the insurance company and I was approved. I later discovered when I got my statement from the insurance company that the insurance company had reimbursed him $60 for that 5-minute visit. However, he had billed the insurance company $100. Because he had agreed to receive the reimbursement from the insurance company, he did not bill me the extra money. I have spoken to several people about this as an example of what can happen when you abuse second opinions. Since second opinions can be abused, they may not be effective.

Nurses are also concerned about demographics and environmental concerns. By the year 2020, it is projected that the elderly population will reach 51.4 million, about one fifth of all Americans. Those elderly people will require a variety of health care services. You have seen the other things that are impacting on the environment; pollution and AIDS, just to name a few. So, what is nursing's agenda for health care? We look at quality, access and cost.

Two of the major nursing organizations, The National League for Nursing and the American Nurses Association, simultaneously agreed to look at how nurses could impact changes in the health care system. Nurses have been lobbying in Washington for nursing education and other things for years. So, nursing developed its own agenda for health care. The main architects of the nursing agenda for health care, the National League for Nursing and the American Nurses Association agreed to get other nursing organizations to join

them. Numerous nursing organizations are now supporting this agenda. It includes well over one million nurses. We have built this agenda by consensus, by going to various organizations, talking, and sharing ideas. Nurses believe that the health care system must be restructed. You really cannot just focus on cost and access. We believe that it must be restructed and decentralized. There are some criteria that we have kept in mind. It must be consumer focused. Health care needs should determine the programs and services. There must be universal access, all citizens should have access to essential health care services. But essential health care services must be defined by the public and the providers by working together. Essential health care services should include services such as prenatal care, preventive aspects, and immunization for children.

The third criteria that nursing has used is that primary health care services must play a prominent role. Consumers must have access to a full range of qualified primary providers. We believe that nurse practitioners and advanced practice nurses can also serve as primary care providers and, in some instances, so can physician assistants.

I am a member of a primary care task force that is currently working on the State of Ohio. This task force developed because the medical schools in Ohio were directed to look at the need for primary care physicians in Ohio. The task force has made some recommendations about how to increase the number of primary care physicians. At the same time that, the Robert Wade Johnson Foundation sent out notices to all 50 states that they were going to seek grant proposals to develop primary health care systems. So, two medical schools, Wright State University and Ohio State University, contacted several other people in the State of Ohio; the Primary Care Association, The Ohio Council on Nursing, the Ohio Department of Health, Ohio Department of Human Services, Extension Services, and several other groups. They're about twelve groups who meet. We have been meeting since June, developing a project proposal to go to the Robert Wade Johnson Foundation. We hope to receive a $100,000 grant for the State of Ohio so we can take a look of how the primary care system can be improved. I think that it's wonderful that all these groups are working together and it's wonderful that nursing has been recognized as potentially able to serve as a primary health care provider in the State of Ohio.

Nursing wants to restructure services to provide a better balance between the current focus on illness and cure toward a new commitment of care. We want mechanisms to control costs, protect against catastrophic costs and impoverishment, and mechanisms to insure quality of care. We want primary care physicians to act as a gatekeeper. Nursing believes that it could be a gatekeeper. As you have heard, nearly one million nurses are supporting this plan. It is similar to other plans in that we want universal coverage. Nursing has started to look at a single payer system, but at this point we are still committed to the pay

or play plan. One thing that is very important to us is that it be budget neutral. We think 750 billion dollars a year on health care is enough. We would like to see that no new funds are committed for this new system. We are currently having an economist project the cost of the nursing plan, considering that there would be substantial reconstructing of health care delivery and this agenda would entail more community health centers as well as nursing centers.

Unique to Nursing's plan is the shift from acute care to community based prevent ion and primary care, direct payment for nurses and medical effectiveness testing. The shift to community based care would create school based family clinics, nurse managed free standing clinics, community nursing centers, and home care based hospitals. Nurses as well as other primary care providers would act as gatekeepers. Medical effectiveness testing would eliminate unnecessary surgery and decrease defensive medical practice. Mandatory managed care would be necessary as would a federally defined benefits package for every individual. It would provide coverage for immunization, prenatal care, health screening, pap smears, rectal exams, etc. We would eliminate balanced billing that allows physicians and hospitals to get additional fees for what they charge. Long term care services are something that is a great concern for nurses because we see a lot of patients in long term care facilities and they become impoverished from this kind of care.

Nursing believes that a substantial portion of long care services could be covered in the home. Perhaps we could advance home care as a choice for health care to be delivered along with community care. Not only for patients who come out of the hospital early, but also for long term care. We would not provide blanket coverage for all long term care services, but we would advocate public funding to prevent personal impoverishment. We also ask that people begin to plan for this, begin to take some responsibility for their own system. This will not happen overnight, I'm sure you realize. We would not implement nursing's agenda all at once. It would be incremental.

Phase one would provide for pregnant women and children because we see that as one of the greatest needs. There was a survey done by Peter Hart a couple of years ago. Peter Hart surveyed the public to see who in health care system they trust. The public did not trust hospitals, insurers, nor physicians, but they did trust nurses. So nurses thought, let's take advantage of this and plan something that we believe would be good for the American public. We have been trying to establish unity among nurses for support so that we can position nurses as gatekeepers and providers of basic health c are services. The tri-council which is composed of four major nursing organizations and other nursing organizations, nearly one million nurses, support the plan and we are now in the process of educating policymakers to try to help them understand what we are proposing.

We are not proposing a bill, but we are working with current legislators for change.

The key, as we see it, is reimbursement under Medicare for some of the advanced practice nurses so that they can become primary care givers. We are suggesting a revision in the system. Not only will there be primary care physicians, but a total cadre of primary care providers. I hope I have given you some indication of what nursing is hoping to accomplish. We believe it is a consumer focus and that Americans are eager for a change. We are ready to help develop a system that looks at access, costs, and the quality of care. Thank you.

Our next speaker is David Weil. I know David quite well because David was a law clerk for me out at the medical school. David has also clerked at Aultman Hospital in the Department of Legal Services. He is also a graduate student in the College of Business Administration on this campus as well as a candidate for the Juris Doctorate Degree. He is a member of the Bio-ethics Network of Ohio and the National Health Lawyers Association. He also has received a number of honors. I am glad to have David here with us today and I am going to turn the program over to him and he is going to bring us up to date on some of the legislative events. David.

Representative Paul Jones, Senator Bob May, Senator Roy Ray, and Senator Bob Nettle. It is very unlikely that anything likely will come about prior to the elections. Basically, House Bill 478, known as the Ohio Omnibus Health Care Reform Act of 1991, is just a whole hodge podge of different types of legislation. I selected a couple of significant aspects of each for discussion. First, we are going to look at the insurance law, or small employer health care alliances among employers allowing them to enter agreements with health care insurers and health maintenance organizations to provide coverage for employees. The House Bill has no comparable provisions. The House Bill proposes what is known as the Ohio Plan. The senate has no comparable provision, it did away with the Ohio Plan.

One big problem with the Ohio Plan was that it required mandatory participation by health care providers. Physicians would have to take patients in the Ohio Plan and accept as compensation whatever was in the fund created. This raised an issue of involuntary servitude and the 13th amendment. The senate version has something called open enrollment. This version requires insurers and multi-employer welfare arrangements to hold annual open enrollment periods for certain small employer groups and individuals subject to a specified limitation. The House Bill has no comparable provision. I think open enrollment is being seriously considered as an alternative to the Ohio Plan.

The next significant aspect under insurance law is the Ohio Children's Health Care Program. This is really a big topic right now. The Senate Bill establishes the Ohio Children's Health Care Program. The House bill has no comparable provision. The next significant impact is in basic sickness and accident insurance. The senate version permits sickness and accident insurers to offer basic insurance; covering certain employers, multiple employer trusts, employees and other persons. It generally prohibits employers from obtaining such insurance after the Bill's effective date if the employer provides greater benefits to his employees. So, employers that already provide benefits that exceed those of the bill will not be able to take advantage of this. The House has no comparable provisions.

Another aspect is income tax deductions and credits that the Bush Plan is supporting. The House Bill provides an income tax deduction for any taxpayer who pays premiums on an individual policy contract or plan that covers the taxpayer, his or her spouse and dependents. That is all the House Bill is concerned about with regard to health insurance deductions. The Senate version provides an income tax deduction for any self-employed individual who purchases health insurance coverage for himself, his spouse and dependents. So, the senators are not so concerned about those that don't get coverage through their employers. Limitations on loss ratios and administrative expenses constitute the cost containment portion of the bill. The House provides that the administrative expenses of the sickness and accident insurer may not exceed a specified percentage of the insured premium income. The Senate version is somewhat similar. Regarding refunds for identifying billing errors, the House version requires the provider or hospital to refund to the beneficiary an amount equal to 20% of any identified overcharge on the billing statement. Read those billing statements carefully. The Senate version is substantially the same but they bring in down to 10% regarding standardized forms, the House version prohibits third party payers and governmental health care programs from failing to use a standard claim form. It also requires proof of loss, jointly prescribed by the Superintendent of Insurance and the Director of Health. The Senate was substantially similar, but the discretion was left to the Superintendent of Insurance. That's all I'm going to talk about with regards to insurance law.

The second portion is health care law. The House version creates an Ohio Health Care Alliance. This alliance is made up of six members appointed by the Speaker of the House and six members appointed by the Senate President. Its function is to review reports as to programs and studies. The Senate version creates the Ohio Health Care Board within the Department of Health. This board is made up of sixteen members appointed by the Governor with the advice of the Senate. Its function is to evaluate the social and financial impact of legislation mandating health benefits, develop proposals for health systems reform, and establish and administer a center for health care data. Regarding balanced billing of

Medicare beneficiaries, the house version prohibits specified health care practitioners and their employees from balanced billing. The Senate version is substantially similar. Apparently both houses perceive balanced billing as creating a series of problems with access to health care and its expense. Regarding captive referrals, the House Bill prohibits any physician or podiatrist from referring a patient to a person or a clinic or laboratory services if that physician, podiatrist or any members of the immediate family has a pecuniary interest in that particular person or laboratory. The Senate version is substantially similar.

Regarding the exemption of property from satisfaction of health care debts, the House version authorizes a person to exempt from execution, garnishment, attachment or sale any money owed for health care services or supplies if the property is resident is a motor 8% of disposable used as a vehicle or earnings. The Senate version is substantially similar, but it excludes disposable earnings. That part of the Senate bill may raise an issue of equal protection. Regarding the Good Samaritan Annuity position, the House version excepts the physician or nurse who volunteers services from liability damages in a civil action for administering care to a patient at a shelter or clinic unless these acts constitute gross negligent conduct. These are the key words under the standard. The bill is trying to entice physicians and nurses to provide services at clinics so we can provide greater access. The Senate version has no comparable provision. Regarding Medicaid provider restrictions, the senate version requires the Department of Human Services to establish a health care delivery system that restricts the physician and other providers so that Medicaid recipients may receive non-emergency health care services. The House has no comparable provision. The vast majority of proposals is to set up studies. House Bill 478 is chalked full of studies and I'm just going to briefly go through that. The House version wants to study single payer health care. It's going to establish a joint committee to study single payer health care. The Senate version wants to study Medicaid reform, health care cost shifting and anti-trust issues. The Senate version wants to also look at balanced billing of private third party beneficiaries and the implications of the developing technology of genetic science.

Our final panelist is also a registered nurse. Sharon Dietzel has a Bachelor of Science degree from Texas Women's University, a Master of Science in Pediatric Nursing from Boston University, has been with Children's Hospital Medical Center for 16 years and is currently manager of Child Advocacy and Government Relations.

Good evening and I thank you for allowing me to be here. In preparing my remarks, I began by opening my file drawer where I keep my specific plans for reform of health care. There are at least 50 bills before the U.S. Congress right now dealing with just health care reform. Part of my responsibility is to keep on

top of what we're doing because of my position at the hospital. I can't do it. I have not begun to read all of these [health care proposals], let alone study all of them to really know what is in them and to be able to formulate some decisions about what are the good attributes about these proposals and what are not so good. I found it frightening for two or three reasons. I know the average American does not have access to all these proposals. So how can they be educated in making a decision about what they should want in health care reform. I am also afraid that the American public in general, the average American, is going to look to our elected officials and let them handle it for us. It is frightening to me because I know the vast majority of our elected officials have not had time to read and digest all these bills and proposals either. Nor can they be expected to be experts in all different phases that are playing into our health care delivery system. So I decided that I was going to take a road less traveled here tonight. The good news is that there is consensus that change needs to occur. I would like to hope that we're halfway to a solution, but I am not sure that we are. The problem is where do we begin? It's not that we haven't tried.

First, we tried to address the indigent population with Medicare and Medicaid, but cost went up. Then came regulatory measures such as certificates of need, price and wage controls, etc. Health care costs went up again. Then we turned to competition, to see if we could do it the American way. Again, health care cost rose. Then we introduced the RG's under the Medicare system and while they have been somewhat successful in controlling inpatient costs, outpatient costs have soared. Even with the HMO's and PPO's that we put in place, which are saving patient's money, there is evidently no overall change because of cost shifting by physicians, hospitals and so forth. So, despite all these failures, we do need to experiment.

As Governor Lamb from Colorado said, "It would be reckless for us to develop a health care system for 250 million people, American people, without practical information on all the alternatives." So, I think that we should consider some of the following when we are talking about health care reform. No one bill at the federal or state level is going to solve our problems. The health care system in place right now does serve the vast majority of the Americans well. We should work to fix the part that doesn't work rather than throwing out the whole system and starting over. Collaboration from and with all entities must take place. This is no time for us to pork barrel legislation or lobby for individual organizations and associations. I would even submit that the collaboration needs to come apart and aside from legislation. At least the majority of it needs to happen like some of the things we are doing here in Akron and Summit County. There is no new money for us to spend on health care. We are going to have to take from the excesses, from the places where we are spending it wrongly. We also must recognize that we must all give up a little bit in order for the whole to survive. Everybody will have to give a little bit. If everybody gives a little bit, then no one person or en-

tity is going to have to give a whole bunch. We also need to feel our way toward a solution. In other words we need to experiment. Probably one of the better ways to do that is for each of the states to start experimenting and coming up with alternatives so that we can see what works and what doesn't. It's better to do it on a state basis rather than having the federal government put in something that may not work for the whole. We need practical data on issues such as control and spending, reducing malpractice cost, exploring ethical issues, and matching health care supply to demand. That's my overall feeling.

Before closing I do need to address the health status of children. The health status of children has been declining and it is very well documented. It cannot be ignored when we address all these other issues. One in six children is without health insurance and that means they are not covered by either Medicaid or private health industry. The U.S. surpasses almost all other developed nations in adolescent pregnancy, adolescent suicide and sexually transmitted diseases. We rank 21st in the world in infant mortality. In my county, Wayne, 50% of our children are not immunized by age two and that is not the inter-city. Our recent study showed that upper middle class suburbs have the same problem. One thing that most people do not realize is that children account for half of all Medicaid recipients, but they only represent 20% of Medicaid spending. We cannot afford to leave our kids behind, they are the future of our country. Thanks.

We are very fortunate to have had panelists as well as legislators from both the state and federal level who have really done their homework and who are involved in health care delivery.

There is an antidote I always like to recall about a senator who was reading on the floor of the Senate from some learned book and most of the senators were not paying attention to him. Finally, he paused a moment and said, "My colleagues, I want you to listen to what I am reading to you. These are not my words, these are words of someone who knows what he is talking about." Fortunately tonight, we have heard people who know what they are talking about and the attentiveness of this audience attests to that fact.

We are now ready for questions and I wonder if anyone has a burning question that they want to send to any one of our panel or the panel as a whole?

Let me ask a question just to get the ball rolling. As the last speaker mentioned, some countries, Germany for example, have had national health insurance for over a hundred years; and the United States, I am told, is the only one of the advanced industrial countries that does not have a national health insurance program. Living with the present program and all the different insurance entities, I am struck with the fact that it is to some extent kind of like patchwork. There are all kinds of gaps and inconsistencies and inequities built into it and it seems to

me that any program should have an ultimate objective even though we may have to go through steps to get there. We learned with the welfare system that it is inefficient as well as ineffectual and distorts behavior of people. People were migrating from one state to another because they got higher welfare, so we finally went to national standards. We've done that in a lot of other areas for the same reason. I wonder if any one of our panelists would care to address that question; whether we should have some kind of minimum standards for every state that are required by law. Wayne, you want to address that.

I think that right now we do have a national system if you look at Medicare and Medicaid. There is a structure in place that is uniform across the states and to take it one step further would be a relatively easy transition; not as large as a lot of people may think. I have a real problem with the federal government and how they manage some of the programs. I have those concerns. I am a state person, not just because I am in the state legislature, but because I think we do a better job on the state level of watching the store than the federal government does. I think that the S&L situation and state regulation of insurance kind of parallel in some ways. We've had some problems with insurance companies, but it hasn't been to the extent that it's happened in the S&L industry. I am not ultimately opposed to a national health care system, but I would be very much opposed to a state by state system of universal health care.

Miss Snyder, do you want to comment on that?

When you talk about a government administered insurance plan, we have two examples currently in existence. One is the Medicare program that's administered by the federal government that is fraught with problems; and the other is the state workers' compensation system that is administered by state government and it's an absolute disaster. So, I guess I have no great confidence when you are talking about a national system, a government administered system. I have no great confidence that it would be an effective approach.

This is for Wayne Jones. From what I understand, one of the major issues that has blocked the Senate and the House version of H.B. 478, is called the child health care plan. What do you perceive as being the most likely manner in which that plan will be financed?

I was in Columbus today meeting with some people I would like to get to support that amendment. I was talking to the Ohio Hospital Association today at lunch. The child health care plan is the plan I was telling about for 335,000 kids. We believe if we take care of every child from zero to nine, we are looking at approximately 19 million state dollars. That would be leverage for federal dollars. If we take care of every child in the state of Ohio, we are looking at 48 million dollars that would be leverage for 121 million dollars needed to take care of the

plan. I have proposed that hospitals pay an assessment up front so we can make 40% share and leverage the remaining 60% from federal dollars. We are basically going to be the biggest beneficiaries of the reimbursement. So, that's the way we are looking at it. The problem is we are dealing with it from the state budget. I think it's real clear we are in a huge deficit right now, somewhere in the range of $200 to $500 million. I think that the problems of the economy are such in this state that we have to look for volunteers. That's why I talked to the Hospital Association. They have not given me their answer.

It was interesting what you said that we tried so many things yet the price of health care kept going up and I noticed in Miss Snyder's comments on the Health Access America where you stated what the doctors want to do about the containment of cost. Everybody else is doing something but I didn't notice what the doctors were going to do in containing cost. I would be interested in hearing about that. Another thing for Representative Jones, for the Cleveland quality choice program, we do not reward our health care providers for quality and efficiency and that is what Cleveland Cosie group and some other groups are going towards in the Cleveland quality choice program. And how do you feel about enforcing state-wide procedures by obtaining data from the Hospital Association and reporting that data so employers will have the information, and people will have the information so they can go to those hospitals and providers who are more efficient and cost effective?

Two questions, one for Miss Snyder. What is the doctors plan for controlling costs of health care? And, to Representative Jones, how do we get information about the quality of hospital care and get it into the hands of employers and others?

Miss Snyder: The cost containment aspects I mentioned are contained in Health Access America. Those that impact physicians, the development of a standardized billing and promoting electronic billing, will lower office overhead which is staggering. The development of practice parameters that could work in conjunction with malpractice reform, would also give us some guidelines to determine if there are these multitudes of unnecessary tests and treatments going on. The anti-trust protections that I mentioned will allow physicians to discuss what their fees are and stimulate a little inter-physician competition when it comes to pricing policies and the malpractice system.

Representative Jones: Cynthia has a tough job defending those physicians. I think that one of the things that appears to work as far as the rate issue is the IBRS system, the resource base relative value system, that's been put in on the federal level for Medicaid reimbursement. If that was applicable to all payers, I think you would see a shift from the increased proliferation of specialists and the fees that they charge. They're the problem; it's not the family doctor. The family

doctor does not make enough money in my view. They are making $70,000 to $80,000. But, you have specialists who think that they should have a job, drive a Mercedes and have a million-dollar home the first year they are out of school. There is no control on them and there should be. With regard to the question on managed care data collection on the state level, there is a provision in H.B. 478 that deals with data collection from all levels. The one thing we want to look at first is that it's very expensive to collect this data. We don't want to collect data just to have data. We can look at the hundred most common diseases that account for, they tell me, about 85% of the health care dollars spent. We can do some data collection on costs, on outcome, and utilization that will tell as it's not necessarily better to spend more. I think those companies that have done that, like Your Choice and Cosie, are beginning to realize that the doctors that utilize more are having better outcomes, they are getting more money and the only way to do that is through a data system. I will tell you we are being fought by the insurance companies and the providers that don't really want data collected by the government. Maybe one of the things, talked about today in another forum, is to have the private sector collect it and give them some quasi governmental authority to share it with the pubic. But, let the private sector collect the data. They are the ones that really have all the data because they pay the bills.

My question deals with sharing risks. As a taxpayer, every time I hear that phrase that means my contribution is going to go up. My question is why do we have to share the risk for people who choose to abuse their bodies with drugs and alcohol, or whatever? Are there any portions or clauses in the plans to exclude these kinds of things?

Miss Snyder: I don't think I used the term "share the risk." I said we're looking for action or compromise from all the interested parties. At one point, H.B. 478 had a call for a reduction in premiums for those people who don't smoke and don't use tobacco products. That hasn't survived to the best of my recollection. I think you asked a real silent question. Should we be responsible for paying for these people? I think that's not something I can answer for everybody.

It seems that some of these proposals are trying to provide complete coverage for every single person in America for every illness and I am wondering if there is a way or any provisions where we could try to curtail the cost by excluding people who choose to abuse their bodies by drugs and alcohol? Our proposal encourages healthy lifestyles, but it does not have any punitive aspects for those that choose not to follow that advice.

Mr. Jones: .Just a couple problems. Healthy lifestyles will definitely save health care dollars. We had a tobacco provision that was taken out by the Senate because it was unenforceable and hard to determine who smokes and doesn't

smoke. The drinking issue is even harder to prove. If you drink way too much, to fall into the disease category where you cannot stop, then, it turns into a disease, so we have a real problem enforcing it. But, if you say exclude everybody that smokes, exclude everybody who drinks, exclude everybody who eats too many twinkies, you start excluding everybody who is on insurance. We're going to pay for them eventually because the hospitals are not going to turn them away. I think education with kids as they are growing up will promote healthier lifestyles.

Well, I think that we have had a very interesting discussion tonight and I want to thank the panelists as well as all of you who were here. I hope you all get home safely and find that this has been an illuminating experience. Thank you very much.