Layperson to Layperson

Fall Forum Introduction

by Jay Hutchins

In this issue, Richard A. Clucas, Ph.D, Richard Ellis, Ph.D, and E.D. Dover eruditely and engagingly describe the role of conservative and progressive populist movements in shaping Oregon's current political culture. These excerpts are from *Oregon Politics and Government: Progressives versus Conservative Populists*, edited by Richard A. Clucas, Mark Henkels, and Brent S. Steel; they have been adapted with the permission of the University of Nebraska Press.

Richard Ellis discusses Oregon's initiative and referendum process and its origins in progressive populists' beliefs that politicians were corrupt. He points out that populists used the initiative system to, among many things, enact laws and amendments to open up the primary process, expand the initiative process to cities, and establish the Corrupt Practices Act. Dr. Ellis is an expert on the initiative system and he describes how it has changed over the years to become an institution driven not by the demands of the public, but by activists and professionals.

Richard Clucas in *Partisan Politics Shapes Oregon's Political Culture* discusses how contemporary Oregon government and politics remain strongly influenced by the Populist movement that arose more than 100 years ago. The underlying values of Populist groups help explain the ideological division between modern progressives and conservatives in Oregon politics.

Also in this issue, we begin what we hope will be an ongoing discussion on a subject that has fascinated us for a long time: the separation of church and state. Frank Pasquale, who has a PhD in cultural anthropology, and Phillip Wong of Ecumenical Ministries carefully and tactfully describe their views on the role of religion in politics. Political sciene Professor Robert Schmidt, PhD, brazenly challenges both of their positions indicating that populists on the conservative side of issues are supported by big business and that liberal politicians may be hamstrung by the left's anti-religious inclinations. We are committed to continuing this important discussion in future issues.

And Then, There is Healthcare

This is an incredibly urgent yet complex topic, so plan to use the Healthcare Glossary included in this forum to better understand the terminology.

One frightening and indisputable fact emerges in studying this issue: the healthcare market is quietly generating a mountain of inflation that threatens to bury taxpayers and especially those covered by private insurance. This is much more than providers shifting costs to private insurance companies for services they cannot charge to Medicare and Medicaid (fees set at 50% of what is normally charged). The prevailing understanding now is that medical inflation is caused by inefficiency in the healthcare industry not by the Medicare and Medicaid fee structure. Health economists now believe the federal government fee structure is a response to medical inflation, and not the cause. Providers have reacted to price controls by raising their fees even higher for those with no insurance and those with private insurance, or they have simply stopped taking publicly funded patients.

The market is quietly generating a mountain of costs that will bury those covered by private insurance.

Inefficiency rules the day because insured consumers have historically treated healthcare as if it were free. As higher premiums push more patients into the Medicaid system or into the ranks of the uninsured, a smaller and smaller pool of privately insured people actually pay the prices of double-digit medical inflation.

Health economist now believe that this cycle, driven by a lack of proper incentives to provide inexpensive care, is responsible for double-digit inflation in healthcare and the growing ranks of the uninsured.

Inefficiency in the healthcare market not only causes financial burdens; it threatens access to healthcare and the quality of life in Oregon. This inefficiency in what people call the fee-for-service paradigm puts at risk the health security of United States and all other modern nations—all of which have universal healthcare systems. The universal-care systems that we have studied lack electronic health records, project huge increases in costs in the next ten years, and according to recent studies have even larger problems with medical errors than the United States. And yet, these universal systems still provide care more cheaply per capita than our system.

The discussion on healthcare in this issue actually begins in Richard Clucas's article on populist politics when he describes the effect of populist attitudes on the political climate that determined funding for the Oregon Health Plan. Then, in the Religion and Politics section of this issue Phillip Wong uses healthcare as an example of a vital resource about which he thinks religious groups are duty bound to inform the political process.

The healthcare proposals of the two presidential candidates seem to reflect ideological tensions in the country as a whole. The forces in contention are the free marketers and those who want our government to actively manage healthcare as other economically developed nations do.

According to Kenneth Thorpe, a well known and respected health analyst from Emory University, John Kerry's healthcare plan would spend approximately $900 billion over the next decade to shore up the

current health insurance system in the United States. More Americans, including a portion of the 44 million uninsured, would get coverage either through their job or through government programs. According to Thorpe, who is being conveniently quoted by both campaigns, Kerry's approach will reduce the uninsured by 27 million. Included in Kerry's proposal are funds to reduce insurance rates by having government pick up the cost of any care above $55,000.

By contrast, President Bush has proposed approximately $90 billion in tax breaks over 10 years to help people purchase individual insurance. Health Savings Accounts and business associations that utilize pooling are part of his strategy (see Healthcare Glossary). Thorpe estimates that Bush's plan will cut the uninsured by about 3 million. Many economists believe these changes could be the first step towards significantly reducing the role of employers as purchasers of coverage. The Bush administration intends to develop tax-based incentives to increase the roll individual consumers in the health insurance market. A more developed explanation of the issues and the unique history of our third-party-payer model can be found in our Healthcare Glossary.

According to Dr. David Sanders of HealthOregon, neither Mr. Kerry's nor President Bush's proposals will solve the healthcare crisis. In his interview, he explains that our healthcare market pays physicians to do things rather than fix problems and that fundamental changes are needed for healthcare to be affordable to middle-class Americans. Dr. Sanders would like to create a system based on fee-for-condition in which providers would be paid for solving problems rather than performing tasks.

Support for Dr. Sander's contention that providers do not have the proper incentives comes from a notorious example of waste. Between 1992 and 2002, according to The Journal of the American Medical Association, 10 million women who already had their cervixes removed received PAP smears. No professional organization recommends PAP smears for women without a cervix except for a minute fraction who have unique situations. All of the physicians, clinics, and hospitals that provided these tests received payment. Clearly, no one in this scenario was worried about the costs of these unnecessary tests.

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However, it is important to keep in mind that this type of waste occurs because the healthcare industry also has an information problem. In this issue, Dr. William Hersh updates us on the state of health-information technology and bi-partisan efforts to create government incentives for physicians to invest in a universal information system.

Dr. Rajiv Sharma in his article *How the Healthcare Market Differs From Other Markets*, discusses the extraordinary value Americans place on health and increased longevity and how economists determine this value. His comments further illuminate the danger of treating healthcare as if it were free: innovations in expensive, high-tech procedures and drugs have been favored over innovations in efficiency in our healthcare system. Dr. Sharma's insights give perspective to Dr. Robert Lowe's article and his discussion of the uninsured, disease-prevention, and so-called emergency-room care in his article *The Hidden Costs of the Underinsured*.

Dr. Sharma also comments on the expensive interventions, common in the United States, which do not take place in developed countries that have universal care. These include over-use of MRIs as well as heroic interventions that add only months to the lives of patients with extremely rare cancers. A point worthy of mention is that most countries that do not pay for such interventions, including Canada, still have lower mortality rates than the United States. The catch twenty-two here that our behavior seems driven by our cultural inclinations to put off death at any cost, while these interventions take away resources from prenatal and other preventative care.

In order to give us a better understanding of healthcare in Canada, Mark S. Kaplan, DrPH, in *Myths and Realities of Canadian Medicare*, describes what he learned about the Canadian system while there on a Fulbright Scholarship. He points out that mortality rates for all ages are lower in Canada than in the United States. Dr. Albert Dipiero of HealthOregon in *Universal Problems and Universal Healthcare*, compares the programs of five other nations and shows how universal-care systems reflect the cultures that created them—demonstrating that the single payer system may not be the only answer.

In the United States and Oregon, topical issues such as re-importation of US-manufactured drugs from Canada and other countries, and changes in medical malpractice tort law dominate the public healthcare debate in Congress and the press. We addressed the issue of medical errors and caps on claims for malpractice in our Update Forum (Spring 2004). Such issues are pertinent because they reflect basic ideological tensions between two ways of looking at the world, including beliefs about what constitutes a viable society and how to motivate people to create one.

Though, we believe that changes in the level of malpractice awards may improve access to healthcare in Oregon, we also believe this type of legislative intervention will not solve the problems of medical errors or the increasing costs of access in the future. Likewise, re-importing drugs from Canada and other countries will not significantly reduce medical inflation over the next ten years.

According to our authors, the important debates—and the real solutions—lie in the same course many other nations are taking to address the problem of medical inflation: creating incentives to reduce costs and invest in efficiency through information technology, disease-prevention, and the use of evidence-based medicine.