LET THE GAMES BEGIN: THE HEALTHCARE SYSTEM IN CRISIS

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This is the third article in a series on healthcare policy and the critical role played by healthcare providers in policy development. The first article described the overall framework within which public policy decisions are made. The second provided an overview of the major trends and current forces that are defining the healthcare policy agenda. This, the third article, offers a snapshot of the current congressional players and policy arenas that will drive significant shifts in healthcare policy in the midst of the current healthcare crisis, defining healthcare over the next decade and beyond.

Myth: Public policy decisions are the result of a rational process that generates a solution based upon the facts, and is steeped in careful consideration of options and their respective merits. A final decision is selected when the best choice becomes obvious.

Truth: Most public policy decisions are made when the group decides that it is time to make a decision—usually when making a decision can no longer be delayed. The final solution is selected because the group determines that it is time to choose, not because an ideal solution has been determined. If the ideal solution is not on the table or lacks sufficient political weight, it will not be selected when the decision window closes.

The good news is that after years of rhetoric, hyperbole, and denial, nearly everyone now agrees that the US healthcare delivery system is, indeed, in crisis—a major fix is needed, and right away. The bad news is that the rush for quantum change in the system may not lead to good policy decisions.

Healthcare policy is an enormously complex and multi-layered collection of issues and interests. Hence, there is no simple policy or strategy that can be adopted that will resolve the myriad of current problems (rising costs, increasing numbers of uninsured patients, declining health indicators, etc.), nor anticipate and address the future. So efforts to improve the current system have primarily generated incremental changes in the ***status quo***.

Quantum change is extraordinarily difficult and rare, even when there is consensus that quantum change is required. Further, large-scale change seems possible only when induced by a crisis, and is typically accompanied by a host of unexpected and unintended consequences. Will the cry of "crisis" and the mounting flurry of federal activity lead to good policy decisions?

The challenge to crisis-driven decision making, however, is that while it allows large-scale change, it also tends to shorten the decision window. This often results in the selection of solutions that are not fully thought through. The desire to get out of the crisis seems to say, "Let's just do something—quickly," rather than promoting a thoughtful analysis and supporting a strategic decision process.

Is healthcare in America now a crisis? Yes. It has been for quite some time. What has changed is that the word "crisis" is now heard more and more, particularly lately as politicians begin staging for the 2004 elections. Therefore, we have the potential for significant shifts in public policy, and the pitch of the discussion is building to such a degree that a decision window is opening. One way or another, large-scale decisions will soon be made—perhaps quantum change decisions.

Shifting the healthcare paradigm to appreciate and embrace the value of integrated healthcare would be, by definition, a quantum change. If the healthcare crisis creates an opportunity for a quantum change, what will it take to ensure that the change will indeed include integrated healthcare? The key is whether integrated healthcare will be visible enough and represented enough to be included in a short decision window.

The past, too, will influence the emerging crisis discussions. The healthcare crisis of the 1980s spawned a private-sector approach called managed care. The hope was that this would alleviate the need for governmental intervention. In short, managed care became "managed cost," later became "managed complaint," and in the end has been declared "insufficient." In the early 1990s, the Clinton Administration attempted a "big fix" for health care, but too few saw it as a solution to a crisis, and the initiative was quickly driven into partisan politics and squelched. Today, by contrast, healthcare is widely defined as "in crisis" by both sides of the political aisle, and it is seems generally accepted that government intervention, in some capacity, is the only solution.

Integrated healthcare, the role of complementary and alternative medicine, and the trends toward health and wellness are subsets of the overall healthcare policy debates that are now heating up at the federal level. To what extent they are seen as an integral part of those debates remains to be seen. We believe their consideration is largely dependent upon whether providers and their patients make their voices heard and assert their opinions ***now***.

In the second article, we proposed that successful influence in public-policy formation requires right action in time and place. Here we suggest that the right time and place is the current session of Congress. Specifically, there are several places where providers can influence policy outcomes along with specific individuals who wield the authority to pave the way to those outcomes.

Perhaps the primary environment where policy outcomes can best be influenced is the US Congress. As was discussed in the first article in this series, there are six congressional committees with jurisdiction over healthcare policy. While all new laws must come before all 535 members of Congress as proposed legislation, it is in these six committees where most of the genuine exploration takes place, from the smallest and most incremental of proposed policy changes to those of quantum proportion.

THE US HOUSE OF REPRESENTATIVES

There are three committees in the US House with primary jurisdiction over healthcare. We'll examine them here, and identify the players who wield the power on those committees.

House Energy and Commerce Committee

The House Energy and Commerce Committee has a Subcommittee on Health, which considers all proposed policy changes for public health programs, mental health services and research, biomedical programs, Medicaid, national health insurance, food and drug law, and substance abuse. This subcommittee also has primary jurisdiction over healthcare professional workforce policy, including National Health Service Corps programs. In general, most healthcare programs that don't relate to the financing of healthcare must first be approved by this subcommittee before advancing through the legislative process.

The Chairman of the Health Subcommittee is Representative Michael Bilirakis (Republican–Florida). Representative Bilirakis represents the Clearwater region of Florida, and has served in the House since 1983. Among the healthcare issues about which he cares most deeply is providing access to primary-care services in rural and medically-underserved areas. In fact, he sponsored legislation last year which was ultimately signed into a law that strengthened and improved the federal Community Health Centers program and the National Health Service Corps. As Chair of this Subcommittee, Representative Bilirakis, together with the Chairman of the full committee, decides which measures will be considered and which measures will be tabled.

The Ranking Minority Member of the Subcommittee, or most senior democrat, is Representative Sherrod Brown (Democrat–Ohio). Representative Brown represents the Elyria and Medina regions of Ohio, and has served in the House since 1993. Among the healthcare issues about which he cares most deeply is funding for breast and prostate cancer research, and strengthening the Food and Drug Administration's authority to improve the safety of imported food, having argued that America is facing a "food-safety crisis."

While Representative Brown serves in the minority party, many would suggest that his power is limited. At first glance, that might appear to be accurate. However, the minority party today plays a key role in the development of public policy. Since all legislation must pass both the House and Senate before it is signed into law, and considering that the Republican majority in the Senate is razor thin, only legislation that has earned general bipartisan support will make it to the President's desk. Republicans and democrats have to work together and compromise on the range of issues facing them, or nothing will get passed. Secondly, today's minority party could be tomorrow's majority party. It takes just one election to facilitate a changing of the guard, and should the Democratic Party capture the House majority in November of

2004, Representative Brown would find himself as Chair of the Subcommittee.

House Ways and Means Committee

The House Ways and Means Committee, another committee in the House of Representatives with jurisdiction over healthcare issues, also has a Subcommittee on Health. This particular subcommittee considers all proposed policy changes regarding the financing of healthcare, specifically health insurance premiums, healthcare costs, and certain sections of federal Medicare and Medicaid law.

The Chair of the Subcommittee is Representative Nancy Johnson (Republican–Connecticut). Representative Johnson represents the New Britain and Waterbury regions of Connecticut, and has served in the House since 1983. Promoting policies to strengthen community hospitals, home health agencies, and other providers, as well as extending Medicare coverage to cancer clinical trials, top the list of those issues on which she has been particularly active.

The Ranking Minority Member of the Subcommittee is Representative Pete Stark (Democrat–California). Representative Stark represents the Fremont region of California, and has served in the House since 1973. Promoting parity for mental health insurance coverage, improving the quality of care in nursing homes, and "fighting excessive drug prices" are the issues in which he was active during the last session of Congress. Representative Stark was also the name behind the federal "Stark Rule," which prohibits a physician's referral of a Medicare patient to an entity for the provision of services if the physician has a financial relationship with the entity.

House Appropriations Committee

As discussed above, the House Energy and Commerce Committee and Ways and Means Committee are the two committees which authorize federal healthcare legislation. However, any program authorized by Congress still requires a mechanism to pay for it. That is the responsibility of the Appropriations Committee. Each year, it is the job of the Appropriations Committee to make funding recommendations for all programs in each of the many federal agencies, and to advance those recommendations to the full House and Senate for a vote. With respect to federal healthcare programs, the House Appropriations Subcommittee on Labor, Health and Human Services, and Education has primary jurisdiction, and appropriates approximately $100 billion annually. This is the subcommittee, along with its counterpart in the Senate, that decides funding levels for the National Center on Complementary and Alternative Medicine (CAM).

The Chair of this subcommittee is Representative Ralph Regula (Republican–Ohio). Representative Regula represents the Canton region of Ohio, and has served in the House since 1973. He has sponsored measures to extend influenza shot coverage under Medicare, and has authored legislation to provide coverage of preventive services to the elderly.

The Ranking Minority Member of the Subcommittee is Representative David Obey (Democrat–Wisconsin). Representative Obey represents the Superior and Wausau regions of Wisconsin, and has served in the House since 1969. He has worked to increase the federal investment in medical research, and to expand access to affordable health care. He believes that every American should be covered by affordable health insurance.

THE US SENATE

On the Senate side of Capitol Hill, there are three committees with primary jurisdiction over healthcare issues. Again, it is important to get to know these committees, and the principal players involved, to maximize the opportunity to impact healthcare policy.

Senate Health, Education, Labor, and Pensions Committee

This Committee considers all proposed policy changes regarding occupational safety and health, public health, biomedical research and development, and health profession education programs. It is the Senate counterpart to the House Energy and Commerce Committee. Historically, there was a Subcommittee on Public Health with jurisdiction over most healthcare programs. However, just this past January, Senate leaders decided to dissolve the subcommittee. All public health programs and proposed legislation will now be handled at the full committee level.

The Chair of the committee is Senator Judd Gregg (Republican–New Hampshire). Senator Gregg was first elected to the Senate in 1992, and has played an active role in drafting health legislation including the Patient's Bill of Rights, bioterrorism legislation, and reforms to the Food and Drug Administration. He has worked on legislation improving access to health insurance, expanding medical research, and increasing the number of community health centers.

The Ranking Minority Member is Senator Ted Kennedy (Democrat–Massachusetts). Senator Kennedy was first elected to the Senate in 1962, and has been among the Senate's most vocal proponents of universal

healthcare coverage. Mental health parity, reducing the costs of prescription drugs, and expanding preventive health services for the medically-underserved rank high on his list of priorities.

Senate Finance Committee

The Senate Finance Committee, like its counterpart Ways and Means Committee in the House, has a Subcommittee on Health that deals primarily with healthcare financing legislation, including Medicare and Medicaid. The Chair of the Subcommittee is Sen. Jon Kyl (Republican–Arizona). Sen. Kyl was first elected to the Senate in 1994, and has taken an active role on various health issues. He has been a principal player in legislation to make HMOs more responsive and legally accountable to their members, and is among the leading proponents in the Senate of expanding access to medical savings accounts.

The Ranking Minority Member of the Subcommittee is Senator Jay Rockefeller (Democrat–West Virginia). Senator Rockefeller was first elected to the Senate in 1984. The healthcare policy areas in which he has been most active in the Senate include reducing the costs of prescription drugs, responding to the shortage of nurses in practice, and providing incentives for doctors to serve in medically-underserved areas.

Senate Appropriations Committees

Like its counterpart in the House, the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education makes funding recommendations for all federal healthcare programs each fiscal year.

The Chair of the Subcommittee is Senator Arlen Specter (Republican–Pennsylvania). Senator Specter was first elected to the Senate in 1980, and has been either Chair or Ranking Minority Member of this Subcommittee for well over a decade. Funding for research at the National Institutes of Health has increased significantly under his chairmanship, including program funding for research in the areas of Parkinson's, Alzheimer's, cancer, and heart disease.

The Ranking Minority Member of this subcommittee is Senator Tom Harkin (Democrat–Iowa). Senator Harkin was first elected to the Senate in 1984, and has been among the most vocal champions of integrated healthcare in Congress. He has promoted annual increases in funding for the National Center on Complementary and Alternative Medicine, and has stated his intention to promote federal anti-discrimination legislation for licensed providers of complementary and alternative medicine.

THE POLITICAL TOPOGRAPHY FOR INTEGRATED HEALTHCARE

Upon review of these committees, and the key players among their ranks, healthcare providers can begin to see the geographic distribution of power for health-system reform. As former Speaker of the House Tip O'Neill was known as saying, "All politics is local." Thus, healthcare providers living, practicing, and voting in Florida, Ohio, Connecticut, California, Wisconsin, Maine, West Virginia, Pennsylvania, Massachusetts, New Hampshire, and Iowa have unique access to the individuals who are key decision makers in healthcare policy. Does this mean that healthcare providers residing in other states will have a difficult time in influencing the course of the debate over healthcare reform? Of course not. We've simply identified the chairmen and ranking members of these committees, but there are many members who sit on each of these committees with an equal capacity to exert influence for their constituents. Remember, each healthcare provider in the nation has one representative and two senators that represent him in Congress, and those elected officials have unique access to the health-policy players. The relationships that exist among members of Congress run deep, and significant opportunities exist to leverage those relationships to promote issues important to you.

These summaries of the people and places are a snapshot of the current federal scene; actually, more like a frame in a movie than a single picture. The forces and trends of the policy process are in constant interplay, and adjustments have to be made as time progresses. Right action, therefore, is not a one-time activity. To have genuine impact, providers must be involved over time.

There are some simple actions that providers can take to ensure that integrated healthcare issues are, indeed, a part of the decisions that will be made during this next decision window:

- Support the election of officials who have demonstrated a track record of support for integrated healthcare. You can do this through direct campaign contributions or through organized Political Action Committees;
- Make yourself and your views known to your Members of Congress. Do the basics: write letters, make calls, and submit testimony. They won't know you care unless you speak up—at the right time. Get involved with your professional association's government-relations efforts;
- Be an advocate to your patients. Prepare handouts

that inform them on the issues, and invite them to voice their opinions. Make it easy for them to participate. Prepare pre-addressed postcards on which they can write a brief comment. Give them a list of the names, addresses, and phone numbers of the people whom they should contact;

- Volunteer some of your time to work on a congressional campaign. Offer yourself as a healthcare resource to your candidate, and advise him or her on issues of importance to the district;
- Encourage your senators and representative to join the "congressional bicameral caucus on complementary and alternative medicine and natural foods." While neither a standing committee nor a body with legislative authority, this caucus serves as a convening place for members of congress with a genuine interest in integrated healthcare to learn more about the issues and the policy implications they pose;
- Consider taking a sabbatical from practice to serve as a health-policy fellow on Capitol Hill. Among the leading fellowships is the Robert Wood Johnson Health Policy Fellowships Program. This program "provides an opportunity for outstanding health professionals to gain an understanding of the health-policy process, to contribute to the formulation of new policies and programs, and to develop in their careers as leaders in academic health centers and in health policy." Information is available at (202) 334-1506 or hppf@nas.edu;
- Consider throwing your own hat into the ring. If you are active in your community, and have the energy and wherewithal to launch a bid for public office, do it! By electing advocates of integrated healthcare to public office, the collective goal of quantum change will be more easily realized.

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