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Prologue:
Reflecting the turbulent times of the United States Congress, Sen. David Durenberger, became chairman of the Senate Finance Subcommittee on Health twenty-seven months after his election as a Republican senator from Minnesota. Now, three years after his arrival, Durenberger has emerged as a thoughtful politician with a moderate voting record and a driving determination to transform the health care system through marketplace principles. Durenberger, a former Jesuit seminarian, takes an interest in issues that often do not catch the senatorial limelight. One is health care, a subject that today means retrenchment and reform. Another is federalism—the relationships between Washington and subnational levels of government. In the last year, Durenberger has spent more time chairing hearings on federalism before a Senate Government Affairs Subcommittee than he has on health care issues.
Durenberger, a lawyer who practiced for nineteen years in Minnesota before winning the only election for public office he has ever run in, is sensitive to that state’s progressive political tradition. He tells GOP audiences in Minnesota that “while a landslide (1980) brings out the best in people,” Republicans must work to enhance the notion that they are the party of hope and a better future, and not ride on negativism. “It is time that the Republican party stood for something more than a political platform from which desperate, unhappy citizens and single-interest groups select candidates for president and Congress. We must not turn our backs on the poor, the elderly, the infirm, the worker, or the farmer. We must not forget our God-given mandate to create a nation of equality, of authority, of personal security,” Durenberger said in a recent homestate speech. Like many Minnesota politicians, Durenberger has a streak of independence. After a meeting with President Reagan on the AWACS issue, Durenberger voted his conscience, against the sale of these highly sophisticated planes to Saudi Arabia.
It was two years ago that I first introduced the Health Incentives Reform Act. Since that time I've learned a lot about health care in this country. I've learned which government programs work and which ones don't work. I've learned about fraud and abuse. I've learned about getting the best health care in the world to the people who need it. And I've learned how much it all costs. But through it all, my faith in the principles underlying the Health Incentives Reform Act has not wavered.

I started out with a strong belief in the value of choice and the strength of the private sector. Somewhere along the way the ideas were translated as procompetitive and that's true, but the underlying theme remains consumer choice.

Choice gives individual consumers the opportunity to select a product or service that best meets their needs. The most successful provider of that good or service will be the one that best responds to consumer desires—whether these desires include cost, quality, appearance, or other factors. These very basic elements of a competitive market do not exist in health care. The ultimate consumer of health services, the patient, is usually insulated from the cost of care by a private or government insurance plan.

When patients do share in the cost of their health care, they find there's nothing to shop around for; in other words, no choices. How many employees have a choice of health plans? How many Medicare beneficiaries do? Not many. And without consumer choice to stimulate providers to be responsive and efficient, we really can't expect doctors and hospitals to change their behavior. More regulation won't cure the ills of our health system. But neither will the status quo. We must introduce the basic elements of choice and competition into health care.

In the course of thinking about these issues I've come to realize that achieving a better health system entails much more than simply enacting a so-called procompetitive bill. No single bill can include all elements needed to make our health system more competitive. The reason we have market failure in health care cannot be attributed to any single piece of legislation in the past. The course to our present state of affairs has been incremental, and likewise our movement toward greater competition will have to be incremental. That doesn't mean that our action will be limited or slow in coming. It only means that we will act broadly and persistently.

An incremental approach requires that a competitive framework be established which can be used to formulate positions on the entire range of health issues. It's very easy for health policymakers to view issues in isolation and forget the contribution each one makes to the whole. You can't expect a business to produce a good product if each division sets its own agenda. There has to be coordination and an overall corporate
strategy. Improving the health system is no different. It needs an overall framework.

I have thought a lot about a framework for health. I have, indeed, developed a set of guiding principles through which I will view health issues in the future. Most of these principles apply to other issue areas in addition to health and are representative of my general philosophy on the role of government in society.

1. **Choices are good.** Government policy should expand choices to the individual, not limit them. Monopolies in service provision, whether public or private in nature, should be avoided. Citizens benefit from choice, whether it's in the form of competition with Ma Bell for long distance rates or in the alternatives to the U.S. Postal Service for package delivery. Government has done a reasonably good job of extending health care choices to its employees through the Federal Employees Health Benefits Program (FEHBP). Similar choices should be extended to Medicare beneficiaries and to veterans.

2. **The government is generally a better purchaser of services than provider of them.** Government does not allocate resources as well as private markets and should directly provide services only when a private alternative is unavailable. In cities like New York, private bus lines are able to make a profit on runs the Transit Commission consistently loses money on despite charging the same fare. Another example is in the area of municipal garbage collection. Those communities like Newark, Kansas City, and Minneapolis that contract out for refuse collection are able to save millions compared to communities that directly provide the service.

   A further extension of this principle is that, if possible, government payments should go through the beneficiary, rather than directly to the provider. Consider the GI bill as an example. Veterans were given the choice of going to whichever institution they wanted for their education. This approach is certainly preferable to building exclusive veterans' colleges to handle all veterans' education. In the area of subsidized housing, special projects conducted by the Department of Housing and Urban Development in Green Bay, Wisconsin and South Bend, Indiana have demonstrated that housing allowances, a form of voucher, give beneficiaries a range of satisfactory choices and made the market more responsive. The same approach should be used with Medicare and Medicaid.

3. **Consumer choice is enhanced as information increases.** Government policy should facilitate the flow of information. Individuals cannot be expected to make sound choices if they are provided with insufficient or inaccurate information. Furthermore, information must be presented in a straightforward and comparable manner. Individuals should not have to compare apples with oranges. Consider the value and popularity
of a publication like Consumer Reports. It helps us compare products on the basis of cost and quality. On the other hand, look at the information the government provides federal employees under the FEHBP. There seems to be plenty of information there, but at least for me it is very difficult to make heads or tails of it. Information must be provided in a usable form.

4. The price of a good or service should be a true measure of its cost. Government policy should not facilitate hidden costs or cross-subsidizations. A good example is the subsidy our government provides for tobacco. It is bad enough that the government gets in there and mucks up all the price signals that would otherwise be shaping the market, but then to recognize that tobacco is so unhealthy on top of that is a contradiction. It just doesn’t make sense. In the health area, Medicare cost allocation formulas often force hospitals to shift legitimate expenses to private, paying patients. Such cost shifting does not save the system any money, but it does distort the price signals buyers perceive. Consumers should get what they pay for and pay for what they get.

5. The government should guarantee access to necessary care. However, standards of access cannot be open-ended and must be realistic. Not every town has a Bloomingdale’s or a hospital or an orthopedic surgeon, but access to these facilities and services is usually reasonable. In the medical area, geographical access is only one issue; there’s also economic access. We provide medical services to those who can’t afford them. But consider the difficult issue we face as medical technology offers us expensive new treatments for disease. True, the treatment may be better, but is it worth ten times the cost? We simply cannot afford a health system which sets standards solely on the basis of available technology with no regard for price. Setting standards for access is a thorny but unavoidable government responsibility.

6. A responsive market will have fluctuations in capacity. Temporary shifts and increases in capacity are to be expected as a market adjusts. Shifting buyer preference causes some producers to increase output while others decrease output. Consumer preference for fuel-efficient cars left our American auto manufacturers with too many large cars and too much capacity to produce them. Even though they are rapidly reducing the size of their models, they still have more capacity than they need for producing large automobiles; but that is not bad, it is just part of the process and government should not be tempted to meddle with it. In the health area, that means getting away from certificate-of-need as a concept to regulate capacity.

7. The government should establish guidelines for quality, but recognize that quality will ultimately be judged by the individual. Consumer protection often takes the form of government regulating the producer and setting
standards for quality. For years the government has tried to regulate standards for mileage and crash restraints in automobiles. The government has also tried to control the use of artificial sweeteners, even though diabetics might choose to accept the risk of cancer to decrease their sugar intake. A more appropriate role for government is to establish guidelines and, as recommended earlier, provide adequate information to the individual making the choice:

8. The government’s role in stimulating competition should be to assure fair market conditions, not regulate its particular brand of competition. We each have a slightly different definition of competition. What’s important is not that we install one particular model, but that we create the conditions that will allow the market to diversify and shape its own future. These are the principles that will drive my personal decisions in health policy making in the future.

As an example of how they might be used, consider health planning. The concept is a good one. When it comes to a community’s health system, citizens should have a voice. But the regulatory authority we have given planning agencies is dangerous and unnecessary. To a planner, excess capacity is the bane of our health system. To a believer in the market, and according to my sixth principle, excess capacity is a part of change and innovation. As I see it, the elimination of all excess hospital beds in a community would significantly reduce the pressures for change within the hospital industry. Franchising may be okay for McDonald’s or Wendy’s, but it is not okay for the government. We should franchise neither peanut growing nor health care, and health systems agencies should not have the certificate-of-need authority they now enjoy.

Certificate-of-need should be phased out. During this phasing out period, the certificate-of-need (CON) law might be modified to allow any new capacity to be built, but require that the facility establish its rates within two to three years of start up based on some level of occupancy, perhaps 85 percent, regardless of the actual occupancy. Such a provision would automatically increase the risk for new construction and change the way in which the hospital financing industry looked at expansion projects. To the extent that the facilities could generate their own demand, the provision would have little impact. But remember, changes in our health system must occur across a broad front; to expect the market to work by simply eliminating planning authority is unrealistic. Flexible capacity stimulates efficiency and competition only when consumers recognize relative costs and have an opportunity to make choices. Under such competitive conditions it would be very difficult for a new facility to generate its own demand.
Turning to the procompetitive legislative proposals, one of which I sponsor, I would like to address several points. I tend to think in terms of public buyers and private buyers. As the major purchaser of health care, government certainly has a responsibility to shape up its own act. Consequently, I have been very interested in proposals which would extend voucher-type options to Medicare and Medicaid beneficiaries. The proposals range from fairly limited ones, like the bill by Sen. Heinz (R-Pa.) to capitate HMOs under Medicare, to broader voucher schemes in the mold of Alain Enthoven’s ideas.

I recognize both the technical difficulties and unknowns associated with a shift to capitated payments, but I believe we must pursue it now. From the standpoint of the budget process, capitated government contributions would make Medicare spending predictable and precise. From the standpoint of the beneficiary, there would be choices—choices which would allow the individual to best match his or her health needs with a qualified health plan. It all fits with my guiding principles, especially the first two.

On the flip side, we’ve got to address all the private buyers of health care. In order for competition to work, choices and incentives must be extended not only to the beneficiaries of government programs, but to private citizens as well. If the private sector does not act voluntarily, then it is the government’s responsibility to establish the conditions for fair competition. Multiple choice of health plans for employees and equal employer contributions are a necessary part of a more competitive system. I would prefer to see these conditions met voluntarily. I believe it can be done through progressive leadership in the private sector.

The following are excerpts of an interview of Sen. Durenburger conducted in his office by John K. Iglehart, editor of Health Affairs.

Q: The Reagan administration has taken some bold steps to change the federal role in the health field. Do you generally agree with these steps?
A: I did not agree with the stated notion of [David] Stockman [Director of the Office of Management and Budget] and [Richard S.] Schweiker [Secretary of the Department of Health and Human Services] that competition was going to replace the existing system and would be here in two years, and therefore we could abandon everything that we have in place. I think real consumer choice and the cost savings that will follow is ten years off. I do not believe we should abandon overnight community health planning. We cannot abandon the progress that has been made in utilization review. On the financing side, the notion that putting a cap on Medicaid is a solution to the financing problem is a lot of bunk. I’m not displaying any antipathy toward the administration’s views in health
care, but I have not seen anything yet that represents system reform. We
do not yet have a clear idea of what the administration's health policy is
going to be. So far, I have opposed the administration's budget cuts on
HSAs and PSROs. It's not that I believe these programs should not be
changed or even at some point eliminated, but until I get an administra-
tion bill that appeals to me, I don't want to give up what we have;
otherwise, we will be overtaken by the providers.

Q: The Carter administration’s cost containment thrust sought to cover the
entire industry, public and private. Do you believe the Reagan administration,
when all is said and done, will concentrate its proposals on Medicare and
Medicaid, or cover the public and private spectrum?
A: The administration has to address both public and private programs.
I am hopeful they will do both. I certainly believe that government must
deal with the entire health industry, not simply its own programs.

Q: One of your principles advocates consumer choice. What, in your view, is
government’s role in creating choice?
A: On the public side, if we continue to reimburse for certain kinds of
sick care services and not for others, if we just reimburse bills at some
established, reasonable, and customary rate, we are doing nothing. So,
first of all, I think we must change the way we buy sick care. Government
has an obligation to create choice in Medicare and Medicaid. Creating
choice will be easier with the elderly than it is with the poor. The over-
sixty-five group is a more consistent population. Their sick care can be
financed under a per capita arrangement adjusted for age, sex, commu-
nity, and previous health condition. Under such a capitation arrange-
ment, government could encourage insurers and providers to offer
benefit packages to elderly citizens who come with an entitlement from
government. On the private side, it is really a matter of appealing to
employers to get off their backsides and start to do something about the
people’s need for affordable health care.

Q: In your principles, you discussed creating choice in Medicare, Veterans’,
and the Federal Employee Health Benefit Program. Does the government have
a role to play in creating choice if employers do not get off their backsides?
A: Eventually the government would have to take steps, probably
through the tax code changes that are in my bill. I do not think we
should do that right off the bat. We have to start with the basic principles
of competition and consumer choice in my bill. If people don’t start
moving in this direction, then government must come along and put a
cap on tax-free employer contributions which finance the health insur-
ance premiums of workers.

Q: Private employers seem quite resistant to moving away from the status quo
in health insurance. Do you get that sense?
A: Yes, but there are employers and there are employers. The Business
Roundtable companies that are a part of the Fortune 500 understand what I am talking about, but many small businesses that relate to the United States Chamber of Commerce—like the shoe store down the street—are more resistant. But we would start with the big employers anyway because you can more easily make change in your community if you persuade the major employers first.

Q: By virtue of your office, you are a political animal. That's the business you are in. Health care is going through a period when the major directions are retrenchment, which seems to be very difficult ground for most politicians to trod. How do you find working with health issues in terms of the strictly limited political rewards that it offers! Is it all just punishment?

A: The punishment does not bother me because I get it no matter what field I work in from people who resist change. It’s always difficult to plow new ground, but those who work in the health arena know we’re on the right track. We can see good changes taking shape in places like the Twin Cities and yet as a political issue, it isn’t worth the powder to blow it to smithereens. I did not get elected in Minnesota by promoting competition and consumer choice in health, but if I am successful, it will be the greatest thing I have done, not only for this country, but elsewhere in the world. If we can do it here, it may have applicability in other places.

Q: In observing the health field over the last decade, I have noticed that it seems that health care is always a second or third order priority for most politicians, even though it is a massive industry. Do you have a similar sense?

A: Yes, I think that is true. The reason there are so few of us is that the only way you politicize this issue is to ferret out some corruption in a nursing home or something like that. It’s also reflective of consumers’ attitudes toward health care. There’s not a great demand for change when people don’t perceive the problem. For the most part, consumers don’t get involved in paying the bill or selecting their care.

Q: Turning to another one of your stated principles, you articulate a preference for government payments that flow through the beneficiary, rather than directly to the provider. That would be essentially the concept of a voucher. What do you believe are the major obstacles that stand in the way of enactment of that kind of an approach, where money is placed in the hands of people who then go out and purchase the product that most appeals to them?

A: I think the major hurdle is simply a general resistance to change, to strike out in new directions that are not completely known. Another hurdle is that the choices are not out there now to allow people to purchase from a range of different products. It’s also the lack of faith in the individual.

Q: You have taken testimony on demonstrations that are voucherlike, for instance, the Health Care Financing Administration (HCFA) projects that strive to determine whether Medicare recipients will opt for enrollment in
HMOs if given the choice. You also have talked about changing policy incrementally. Would you consider an appropriate increment legislation that transforms the way Medicare reimburses HMOs?

A: I really think it is too early to tell from those demonstrations what we have learned and whether it has some general applicability. I am most familiar with the demonstration in the Twin Cities. From my viewpoint, it is not marketed well; that is, the option for Medicare beneficiaries to enroll in HMOs there simply was not presented very well. When I saw the information that was given out to the people, I said I would be hard pressed to buy into that thing. It looked like my Federal Employee Health Benefit Plan offerings. It was health-ese and legal-ese. I think that reflected the concern of HMOs that they did not know what they were getting into in terms of a patient population. Thus, there was an unwillingness to make a commitment.

Q: Whether or not Congress enacts a voucherlike approach to Medicare, do you think the day is far away when the government will, in essence, cap Medicare or budget for it precisely, in other words, to close the open end which now exists?

A: I think that is coming. My fear is that it will not come in a form that leads to fundamental reform of the way Medicare operates, but rather simply a capped program at, say, $50 billion. Government, I fear, will budget only that amount and then lock in the present system without making the necessary changes that will stimulate competition, choice, and the need for consumers to be more conscious of price. I fear that government may simply move to protect its investment, given its determination to balance the budget, but ignore the overriding need to enact broader reforms.

Q: Another principle you advanced is that government should guarantee access to necessary care. Would you elaborate please?

A: I believe government's role is to equalize everybody's opportunity to receive necessary care, but I don't believe it is government's obligation to guarantee access to the most advanced technology without regard to cost. It is our obligation to guarantee access to an average community standard of health care. If an individual wants to go to the Mayo Clinic rather than the clinic in town, I think he or she must be willing to pay extra for that. If I take that stand, then theoretically some folks are not going to get to the Mayo Clinic because they lack the money. But until I become dissatisfied with the level of health care in these small clinics, I think government must place limits on its willingness to pay. When we faced these access questions last year, I opposed the elimination of freedom of choice in Medicaid. But this year I did a 180 degree turn on that. When I looked at the issue in terms of taking the cuffs off of states, in giving them the opportunity to more effectively control costs, I decided that states
should have the discretion to limit choice. Translated, it means if a Medicaid eligible chooses a more expensive hospital, then that would be x number of dollars out of his pocket, but if he goes to a less expensive hospital, then the state would pick up the cost. It's not a total limitation on freedom of choice, but it would place the recipient at some financial risk for opting for a more expensive hospital.

Q: How does the Twin Cities experience, where competition seems to be thriving, affect your thinking generally?
A: The Twin Cities experience demonstrates that consumers like choices and will exercise them but that the changes will come slowly. Only 20 percent of the people belong to other than traditional health plans, yet this number continues to increase. This shows that an incremental approach is needed to implement a system of choices.

Q: Applying your principle that opposes government promotion of cross-subsidies, there are a lot of cross-subsidies in the teaching hospital setting, some of which government promotes by its method of reimbursement. Would you be in favor of putting out more openly the cost of medical education and how those costs are financed?
A: Medical education costs should not be buried in room rate charges. They should be separated out so that teaching hospitals can compete with other hospitals on a similar basis. It is a responsibility of government to anticipate the changes that competition will bring to teaching hospitals and to look at new ways for paying for research and training such as through general revenues or a surcharge on all hospital rooms in an area.

Q: What is your attitude about the increasingly large percentage of hospital construction that is funded through tax-exempt bond instruments?
A: The whole area of tax-exempt bonds will be examined, and the use of bonds for hospital construction will be a part of that review. We need to look at hospital bonds in light of the incentives we are creating for the allocation of our health resources.

Q: Do you consider yourself an advocate of the administration’s block grant proposals as a way to devolve power from Washington to subnational levels of government?
A: I support a return of many responsibilities to state and local governments along with the resources to conduct these activities. Block grants are an appropriate tool for transition. As for revenue sharing, it was started to capture the inflation bonus that the federal government was reaping through the effect of inflation on the progressive income tax system, and to return that bonus to the states. With the implementation of indexing of the federal tax system in 1985, this inflation bonus will be gone. Revenue sharing has evolved, though, into a different role of providing flexibility to state and local governments, and this is an important tool in this transition period as we return responsibilities to state and local...
governments.

Q: Finally, following your examination of the PSRO program, where do you stand now in terms of its future?

A: As I have said, government is a better purchaser than provider of services. If PSROs are effective and useful, then government should buy that service, and the private sector should also be able to purchase that service if it is considered worth the investment. Over the next two or three years, government should move to help PSROs stand on their own. In the interim, government should support the effective programs.