The Future of Federal Health Policy: 2010

BY FELICIEN "FISH" BROWN

Outside the CHA offices in Washington, DC, on April 17 was a thick line of black and blue—hundreds of police officers protecting a meeting of the World Bank and International Monetary Fund from protestors against the effect of the new world economy. Many of the same activists were on hand in Seattle in November, demonstrating against the World Trade Organization and raising consciousness about a future economy that will be more open in its exchange across borders but also will be governed by a multinational bureaucracy.

Like world markets, the practice of healthcare is expanding beyond the traditional boundaries of physicians' offices and hospital wards and turning to the Internet, genetic research and treatment, and alternative medicine. Yet alongside these changes in individuals' healthcare is a system that demands greater structure and efficiency, fairness, and consumer protections. Federal health policy in the year 2010 will attempt to address these concerns.

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Political Environment

Most political analysts have refused to predict the outcome of the 2000 presidential contest because the race is so close. Also unclear is whether the Republicans or Democrats will lead the House of Representatives in the next few years. While the debate in Washington between the two parties is as acrimonious as ever, the public is squarely in the ideological middle. They don't want big and costly new social programs, yet, from guns to butter to healthcare, Americans are more willing to have the federal government step in to correct market failures.

Voters are more likely to be knowledgeable about and have a greater say in how their representatives act on their behalf, and communications technology will support voters' increased input. Picture a debate on the Senate or House floor in the year 2010. Each representative will have an "I-net watch" strapped to his or her wrist, tracking instant results from polls of constituents, contributors, focus groups, and issue leaders before casting a vote on important legislation. While spin-doctors for politicians will always have a niche, policymakers will find it increasingly difficult to control their message to an instantly informed audience and will face higher standards of accountability.

Web-based elections for Congress and the presidency are inevitable and could be a reality by 2010. This change could finally push Americans' lackluster voting percentage above the 50 percent level. While a higher voter turnout does not necessarily translate into greater scrutiny on the issues during elected officials' tenure, it does lay the groundwork for a more active citizenry. The escalating speed of communications and information systems can quickly turn a disparate group of people into a united force. When tragic events occur—such as a shooting, a misdiagnosis or death in a hospital, a faulty children's car seat, or a side-effect from prescription medication—the public will wonder why the government didn't help prevent the incident. Federal policymakers will immediately be on the defensive about why the government did not act. By 2010, elected officials' first response is more likely to be a call for more active government.

Health Policy

While the number of uninsured continues to rise, the number of Americans with government-sponsored health coverage is also rising. Each month sees a new state expansion in the Children's Health Insurance Program (CHIP), and measures to increase enrollment of eligible children are beginning to pay off. By 2010 the oldest baby boomers will be eligible for Medicare; the date could be even earlier if proposals to allow a Medicare buy-in for early retirees are enacted. Many policymakers and advocacy groups, including CHA, have recommended expansions in Medicaid and CHIP to cover more low-income families who either do not have access to employer coverage or cannot afford the high cost of pre-

miums. While Americans generally favor private insurance, in the future they will probably push for new restrictions on insurance company practices to reduce discrimination based on age, disability, or health status.

One prediction that prognosticators are willing to make is that healthcare costs—in dollars and as a share of the economy—will increase significantly by 2010. Higher costs mean less coverage on the low-income end and less willingness on the part of employers to shoulder the burden. Measures to reduce costs that were considered and rejected in the past few years, such as expenditure targets and defined contributions for Medicare, will most likely resurface in the next 10 years. Low healthcare inflation in the mid-1990s and a strong economy have masked the underlying trend toward higher demand for healthcare and higher costs. Even the most rabid believers in the bull market know that bearish days will come upon us sometime. When they do, higher healthcare costs will be noticed.

More than coverage and cost will drive the federal government's expanded role. In the late 1990s we saw individuals who had coverage chafe against the restrictions imposed by HMOs or health plans. In many cases health plans were moving toward better preventive healthcare and coordination of delivery, but the constraints that went with them were unacceptable. Consumers will increasingly look to the federal government to enact "patient protections" and to hold providers' feet to the fire on quality of care. The November 1999 report on quality and medical errors in hospitals by the Institute of Medicine is not new news, and it will take a while for Congress and the new president to sort out the best approach to solutions. But routine federal monitoring of quality is likely in the next decade, even if disagreements over what quality care is and how to measure it continue. Government purchasers such as Medicare, Medicaid, and CHIP will have new tools to determine better quality care, and they will use their clout in the market to steer beneficiaries toward selected providers.

Catholic Healthcare's Response

Eyeing a future of more federal regulation of healthcare and continued federal payment restrictions, Catholic providers might be excused for instinctively rejecting the road ahead. Yet the American political system, despite its flaws, generally still reflects the demands of the people, and Americans are demanding more of their healthcare providers and the overall system. Surely we consumers need a lesson on the limits of healthcare at a time when the potential of medical research and our economy seem limitless. But the baby boom generation is a powerful political force, and by 2010 politicians will resist its pressures at their own peril.

Catholic healthcare needs to embrace the future of health policy, just as the best among us have adapted to the twists and turns of the healthcare marketplace. Policymakers in Washington will need a "practical prophet" who encourages and prepares for the future but does so in a way that does not let health policy outpace the ability of the system to respond. Catholic healthcare can be a voice for smart change: arguing why health coverage for all Americans benefits the larger society; calling for changes in how Medicare and Medicaid pay providers so that individuals get the care they need in an efficient and effective manner; helping federal regulators write rules that protect individuals and improve the quality of care; supporting but also raising questions about the application of genetic research.

Just as the global economy is with us to stay, so is the drive for more and better healthcare delivery. Both promise improved outcomes for society but both will tend to leave some individuals behind. As a result, the federal government's role by 2010 will increasingly be that of a policeman—to enforce the rules, to protect the vulnerable, and to ensure that the system is working for all. □

REFLECTIONS

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tion: A Handbook for Responsible Leadership. Written for bishops, sponsors, and facility and system leaders, the handbook includes reasons why the Catholic Church is in health ministry, the current shape of U.S. healthcare, contemporary challenges, and emerging opportunities.

The coalition, CHA, and CCHC have cosponsored *New Covenant*, an initiative to strengthen Catholic health ministry through formal commitments to specific strategies at the regional and national levels. The *New Covenant* process began in 1995 with a national convocation and continues with regional efforts to advance collaboration.

In a strategic planning session in August 1996, coalition members affirmed the role, vision, and priority initiatives of the coalition. Issues recently discussed by the coalition include Catholic identity, the sale of a Catholic hospital to a for-profit provider, partnerships with other-than-Catholic hospitals, legal rulings affecting Catholic facilities, and activities of the *New Covenant* collaborative process. In 1997 coalition members were consulted in the bishops' development of their statement, "The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry."

Since 1998 the coalition has continued to advance collaboration among church ministries. Last year, the coalition was a key vehicle for the Catholic Solidarity BBA campaign, mobilizing several church organizations to convince Congress that recent Medicare and Medicaid cutbacks were morally indefensible. The coalition currently is planning and promoting action steps as a follow-up to *Ministering Together: A Shared Vision for the Caring and Healing Ministries.* Recently completed by a broad cross-section of leaders, this *New Covenant* vision statement calls for new delivery models, joint advocacy, effective leadership development, and other forms of collaboration on behalf of the individuals, families, and communities we serve. □