Augustana College
Augustana Digital Commons

Speeches and Statements | President's Office

1-1-2006

Exploring the Many Facets of the Health Care Crisis

Steven C. Bahls
Augustana College

Follow this and additional works at: http://digitalcommons.augustana.edu/presidentsstatements

Recommended Citation
Bahls, Steven C.. "Exploring the Many Facets of the Health Care Crisis" (2006). *Speeches and Statements.*
http://digitalcommons.augustana.edu/presidentsstatements/26

This Speech is brought to you for free and open access by the President's Office at Augustana Digital Commons. It has been accepted for inclusion in Speeches and Statements by an authorized administrator of Augustana Digital Commons. For more information, please contact digitalcommons@augustana.edu.

Exploring the Many Facets of the Health Care Crisis

An address at the 2006 Conference of the Augustana Center for the Study of Ethics

Steven C. Bahls, President of Augustana College

Good morning. I'd like to begin by thanking Dr. Dan lee and the Augustana Center for the Study of Ethics for bringing this conference together. Thanks, also, to our speakers. Many of you had a chance to hear Senator Tom Harkin yesterday, and his comments certainly provide a framework in which we can build our discussion. The Senator's comment that our health care system is really a "sick care system", and not a system that encourages prevention or early detection are well taken. We can be grateful to the Senator for his leadership on the issues such as wellness, early prevention of disease and adequate funding for medical research.

And so what is the nature of the discussion today's speakers will lead? Are we likely to have the many issues related to health care in our society solved in time for today's conference "wrap-up", scheduled to begin at 2 o'clock? No. But does that absolve us from the task of holding up these issues to the light of scrutiny? The answer, again, is No.

That is why I am pleased the Augustana Center for the Study of Ethics has chosen this subject for our consideration. Just because a problem is seemingly intractable is no excuse for a college to ignore it. To take that a step further, perhaps it is when a problem is apparently intractable that a college like Augustana should tackle it.

Because Augustana is a liberal arts college, it is particularly well suited to facilitate conversations that involve many facets. Because Augustana is rooted in the Lutheran tradition, it is a place where vexing and divisive questions can be discussed freely and in an atmosphere of mutual respect - even when answers are at their most elusive. And because of Augustana's 146-year tradition of producing servant-leaders who go on to shape communities large and small, nearby and far-away.we are called to be a place which models for students the ways in which the three elements of careful thought, clear expression and personal values can be brought together in the service of the common good.

Although we have not yet graduated the servant-leader who has solved our nation's health care quandary.I stress yet.I would like to provide several illustrations of why I think Augustana College is an ideal place in which to hold this conversation. And to our students in the audience, I hope these illustrations will show how Augustana graduates can make a real difference in looking at health care in a different way.

Consider Dr. Timothy Johnson, who graduated from Augustana in 1958. Today, he is perhaps best known as the medical editor of ABC News. Earlier in his career, however, he and his wife, Nancy, felt called to undertake a medical mission trip to Indonesia. It turned out to be life-changing in many ways, including the fact that it turned

them into the parents of an adopted Indonesian orphan.their son Nolden. Johnson used experiences such as that in writing his thought-provoking and impactful book, Finding God in the Questions, which provides a very practical introduction for the ways in which faith can shape a life. His book deals with many of the difficult ethical questions and faith related questions touching on medicine today.

Consider, too, Dr. Joy West, and the impact she has had and is having on health care delivery right here in Illinois. A 1985 graduate, she provides obstetric care in one of the most medically-underserved communities you'll find in the Midwest - Chicago's Roseland neighborhood. Early in her career, the allure of private practice on the City's North Shore was strong, but eventually she felt called to return to the neighborhood in which she grew up. Now, in addition to guiding Roseland Community Hospital's birth center and leading its pre-natal outreach efforts, she is the medical director for the Nandi (NANN-dee) Teen Clinic, the only health facility of its kind on the entire South Side of Chicago.

Or consider Dr. Elizabeth Lowenthal Hafkin, a 1995 Augustana graduate who passed up a lucrative pediatric research position in Philadelphia for a posting in Botswana, where she and her husband find themselves on the front lines of the global HIV/AIDS pandemic. Listen to her reflection on the path that led from this place.to Baylor College of Medicine.to sub-Saharan Africa:

"My years at Augustana provided me with a solid foundation that allowed me to succeed in medical school and in my career as a pediatrician . . . . As a rare Jewish student at traditionally-Christian Augustana, I deepened my faith through discussions with others. In a world that so often divides well-intentioned individuals based on differing beliefs, I learned that there is truth in the unity of good works and hope for a better world."

Each one of these former students is a piece of the solution to the health care puzzle. One - Dr. Johnson - through the media, has had a substantial impact on public policy. Dr. West, through her commitment to poor communities, is instrumental in improving health care on the South side of Chicago. And Dr. Lowenthal, through her selfless acts of service, has helped addressed the AIDS crisis in Africa.

There is yet one more reason I find it especially appropriate for Augustana to host a gathering such as this. According to research from the National Survey of Student Engagement - which is taken by Augustana students both prior to their enrollment and at the time of their graduation - only 33% of our first-year students come to Augustana College wanting to influence social values. That number more than doubles by the time they are seniors, to 68%. Fifty-four percent of our incoming students want to help others in difficulty, but that percentage increases to 84% during their four years here.

I offer all of this by way of introduction because I want to impress upon you my belief that conversations such as this are entirely fitting for halls such as these. It is from places such as these that the next generation of the nation's new thinkers will come. And new thinkers are exactly what we need if we are to overcome the challenges before us today.

As Bill Ford this week told shareholders of the company his great-grandfather founded, the old ways of doing things simply don't work anymore. For the purposes of this gathering, that observation could not have come

from a more fitting source. The experiences of corporate America are inextricably tied to the conversation we're having today, thanks to an elaborate and still-evolving experiment begun in this country during the previous century.

During the global rebuilding which occurred after World War II, all of the industrialized nations of the world slowly gravitated toward universal health care either funded or directly provided by government. This was impractical - indeed, impossible - in the United States at the time, since it was in the very real near- and long-term strategic interests of the nation that our principles of voter-driven politics and market-driven economics be clearly preferable and pre-eminent over the alternatives offered by the Soviet system of political and economic authoritarianism.

Because of this, the employment-based form of funding health care.and in some cases, even *providing* health care.was the ideal system for the U.S. When it became apparent that this system, though effective, still allowed some persons to fall through the cracks, the enactment of Medicare and Medicaid in 1965 incorporated an acceptable amount of government involvement in a system which was otherwise very much employment-based and market-driven. In the years that followed, the health care sector boomed, as more people had greater access to more medical care options, whether they were provided for by the government or through any form of private insurance.

As the health care sector grew, some became concerned it was growing too fast. At first, the response was increased regulation in an attempt to rationalize the growth. In the ten years following the enactment of Medicare, health care expenditures as a share of gross domestic product rose from 6% to 8%. While today that seems laughably small compared to the current percentage - closer to 14% of GDP - in the 1970s it was enough to prompt Washington to try a change in course.

Instead of more regulation, government turned to the free market. After unsuccessful attempts at creating a national health insurance program - by both Republican and Democratic presidential administrations - two things became apparent: 1), that the private sector would take the lead in U.S. health care, and 2), that there was little inclination on the part of the public sector to restrain the profitability of the enterprise.

After years of this, government - perhaps inevitably - decided to rejoin the fray. But its options for doing so were (and are) very limited, given that it still lacks the political wherewithal to establish a comprehensive health plan. By default, the main thrust of government's response has been to cap what it will pay to providers, often with insufficient regard to the costs the providers must bear in the care they offer.

Facing sometimes arbitrary caps on what they can collect for services rendered to Medicare and Medicaid patients - who make up a considerable portion of most hospital's clientele, hospitals have had to be aggressive in any area in which they have control over pricing, in part to make up for the loss they often incur in serving the public good.

This, in turn, places insurers in an often confrontational role with providers, since most insurers are under great pressure from shareholders to maximize profits. Employers have been reluctant to enter the discourse, and for

the most part their contribution to the dilemma is to leave the field, doing less and less in the realm of health care funding for smaller and smaller groups of employees. Yesterday, we heard Senator Harkin say that medical benefits account for $1500 per auto manufactured in the U.S. - driving jobs to Canada and other countries with comprehensive government health care plans. For incoming freshmen next year at Augustana, we expect each to pay over $4000 during their four years here for Augustana employee health care costs. Employers are limited in their ability to pass on these costs - U.S. manufacturer because of foreign competition, and colleges like Augustana because at some point tuition will make colleges unaffordable to middle-class families.

As if this camel's back needed any more straws, hospitals and individual physicians have their own insurance woes, having to pay malpractice insurance premiums which have gone so high in some communities that physicians - especially such essential physicians as OB/GYNs - have had to relocate or cease practicing. The legal professions - and especially trial lawyers - have earned a bad reputation for seeking exorbitant awards and fees. The overwhelming fear of a bank-breaking jury award prompts many doctors, hospitals and malpractice insurers to settle cases out of court - and this only serves to make the problem worse and the situation more irrational. Worse yet, an unfounded lawsuit can greatly sap a physician's energy and efficiency. Even when doctors win, they often lose because of the emotional toll taken by the lawsuit.

All of this, taken as a whole, accomplishes two things in relation to accessibility. For the purposes of today's conversation, I'd like to refer to these as stratification and Balkanization. The former accelerates the problem of eroding access, while the latter ensures that the problem is perpetuated. I'd like to take the next minutes to address each of those in turn.

Our system is set up in such a way that access to adequate care can only diminish over time, while its structure is such that it resists any slowing or reversal of this diminution. To put it more precisely.there is an unfortunate irony that while many of the reform ideas of the past have failed due at least in part to a fear of health care rationing, rationing is precisely what's occurring now in the absence of reform, and the process will only worsen as meaningful reform is delayed.

To fund health care at any level - from a small business insuring its 6 employees to an entire nation, requires a consideration of shared risk. Everyone who chips in makes a bet that they will get sick sooner or later.and more or less seriously.but that their bets will be covered by the other folks in the game. This, however, is an unsupportable proposition in a system which rewards a stratification of the risk pool.

Two illustrations of how this works: The CEO of a mid-sized corporation tends to get a health package that's at a level somewhat higher than that offered to the company's 150 employees. Because she signed off on the insurance package and she is deemed in corporate structure to be of comparatively greater worth to the overall enterprise, the CEO's plan includes an "executive physical" which is conducted at the Mayo Clinic. An hourly employee, like his colleagues, gets a standard physical in the office of his family doc. The physicians conducting both physicals are equally caring and conscientious. But the one at Mayo has technology that allows him to detect a slight problem with the CEO's heart, which is fixed through interventional surgery. The hourly employee's physician - again, equally dedicated to providing the best care at her disposal - does not have

access to the equipment used as routine at Mayo, and is unable to detect the same flaw in her patient, who dies an unexpected and seemingly unpreventable death several months later.

This scenario leaves out, of course, those persons who have no chance at interventional medicine whatsoever - who are working yet lack insurance for the kinds of doctor-visits that can help people avoid diabetes, heart disease and scores of other ailments too often left to hospital emergency rooms to treat, at a stage when most treatment options have lapsed into futility.

The other way the stratification of the risk pool impacts accessibility is by insulating the well from the needy. Ideally, the wider the pool of risk, the greater its ability to provide for those most at-risk of illness. For generations, this undergirded the notion of retiree health benefits offered by so many major American corporations. But as health care costs have increased to the level that these corporations now face serious threats to profitability, those at greatest risk are simply removed from the pool, and left to fend for themselves.

This issue touches us close to home in higher education. That's because many colleges and universities have opted to spin off their custodial, maintenance and food service operations for reasons of cost-cutting. Since wellness and health maintenance are widely seen to correlate with education-level, savings in the health care costs shared by remaining employees - the majority of whom are well educated - can be experienced when the more blue-collar employees are removed from the risk pool. This was in fact done at a previous institution of mine. And while there are savings to be had from a monetary point of view, there is a moral cost which is far greater. Very few of the hourly employees of such service-contractors enjoy any benefits whatsoever, thereby creating a very obvious two-tiered stratification within the same workplace. We have not done so at Augustana and will continue to resist the temptation - but may wonder how we can continue to buck the trend in light of stiff competition among institutions of higher education.

And so it is that stratification serves to exacerbate the accessibility crisis. Is it a crisis? I would venture the Organization for Economic Cooperation and Development would say that it is, in light of that group's study of 25 industrialized nations which found that while the US had by far and away the highest percentage of its Gross Domestic Product spent on health care (and recall what a considerably large GDP we enjoy) our nation was higher than any other in infant mortality rates - a key indicator of the effectiveness with which health care awareness and delivery reaches a society at all levels.

This creates the bizarre conundrum that former President Jimmy Carter has described that while the U.S. is the clear leader in medical science, technology and research, it "has yet to achieve what all other developed nations have attained: comprehensive health care for all citizens."

So yes, the case could be made that this is already a crisis. But whether it is or isn't, the second element I'd like to discuss is that which perpetuates the status quo and serves very effectively to prevent any meaningful efforts at reform.

The highest price for the health care system which has evolved in this country is its Balkanization.

It is as if each player in the health care enterprise was a separate small nation being played off against the others by some self-interested superpower. Hospitals, Lawyers, Insurers, Pharmaceutical Companies, and Doctors - themselves too often split into warring factions of Internists, Orthopedic Surgeons, Anesthesiologists, et cetera. No one entity has sole responsibility for the situation, and each entity believes it has a compelling case for blaming the other entities for the shortcomings of the system. As such, no one entity would be allowed by the others to take a lead role in reform.

Without dedicated and ethical leaders in federal and state government, the public sector alone cannot be counted upon to lead effective reform. At the very least, however, government is the one entity in the list of those we have thus far discussed that has the potential to bring together the others and shape the conversation in such a way that the primary beneficiary is the society in which we live, and not any component part thereof.

In this entire murky situation, what is clear to me is that new thinking will be needed to address these issues. And what is equally clear is that we do not enjoy limitless time for action.

The questions facing health care are likely to become even more complex and even more philosophical with every step we take into the future.

By way of illustration, I'd offer the 25th anniversary issue of *Science Times*, the science insert of *The New York Times*. In the anniversary issue, Science Times identified the 25 "most provocative questions facing science." Several of the questions touched issues concerning health care, and as a result managed care. The seventh most provocative question was, "What are our replaceable parts?" Dr. Robert Langer, professor of chemical and biomedical engineering at MIT is quoted as saying: "How much of the body is replaceable? I have not come across a part of the body that someone somewhere isn't working on . . . Someday every part will be replaceable . . ." In a very related follow-up, the 11th most provocative question in science is "Could we live forever?" Dr. James Vaupel of the Max Planck Institute in Germany predicts that life expectancy will go up 3 or 4 years per decade, and will approach 100 years by mid-century. And then question number 21: Should we improve the human genome? Shouldn't "everyone have a right to the best versions of genes in our collective heritage, or at least to be born free of the worst ones?

While these questions are interesting to ponder, they also are questions that have significant ramifications for health care. If we have the ability to replace almost every human body part, do we have the obligation to do so? If, through medical advances and extremely costly technologies, we can routinely extend life to 100 years or more, do we have the responsibility to do so? Who will bear the massive costs of such a duty? How do we trade these costs off against others - education, to name only one? Who should be the parties to deciding these questions - politicians? Economists? Philosophers? Theologians? Lawyers?

Politicians might look at these matters pragmatically. Whom do I represent and how can I protect their interests, they might ask. That is not all bad. Yesterday we witnessed a remarkable dialog between Sen. Harkin and one of his constituents with a rare genetic disorder. She thanked him for the work his office had done in supporting research into addressing the problem. Lawyers play a role also. Though plaintiff's lawyers are often maligned, it is true that many have been responsible for shedding light on doctors who are not fit for the job and drug

companies that are negligent in putting dangerous products on the market. An economist might quantify the benefits of medical interventions and ask how we can maximize the dividend of the dollars invested. This certainly is a worthwhile exercise, though economic efficiency does not always address equity issues. For economists and their models to work, our larger society must supply the assumptions. What is the percentage of our GNP that we wish to devote to health care? Are we willing to tolerate shortages? When is there enough health care? What is the relative value of spending on health care versus spending on education and other social programs? Psychologists can enter the fray also. They can help us understand why people act in self destructive ways when it comes to health care. Why do some avoid prevention? What can be done to encourage all to lead health lives? Those who study international matters are particularly important. Senator Harkin held up Canada's health care system. Others hold up Sweden and other nations of Europe. Are these systems really better? Are there shortages? And are the problems created by any shortages worse than the problems in our own system. Philosophers are also important. A philosopher might debate the value of life and the importance of a life well-lived. Theologians like Karl Barth, who value life as sacred (to be ended by God alone) might debate the moral justification for allowing a life to end, when medicine might preserve that life.

Each discipline I've talked about has something to add to the debate. And yet none of them, I would submit to you, can alone address the problem. As I emphasize with our students, solving most complex problems is like turning a crystal. When we look through the facets of a crystal we see the same problem from different angles. Each facet sheds a different light on the problem. And when taken together the facets give the most accurate view of the problem.

But who will turn the crystal? Who will help us look at the problem more globally? Who has the reasoned view? Is it government? It is in the best position, but has failed to demonstrate leadership. I submit that it is people like those in this room, who by virtue of a liberal education or wide experience can turn the crystal.

So most of us are here today to learn the answers to the seemingly intractable issues in health care. Many of us are looking for a solution with only advantages and no disadvantages. And some in our country purport to have that solution. Some insurance company executives blame it all on the lawyers. And lawyers blame insurance companies. There are plenty who blame medical doctors, while medical doctors often spread their share of blame. Democrats blame Republicans and Republicans blame Democrats.

As I mentioned before, many voices will need to be part of this conversation. Bill Leaver represents not-for-profit, mission-driven hospitals open to change and innovation. And Nicole Carkner represents new thinking in the realm of public health. These are certainly critical voices in our conversation, and I'm grateful to both of them for joining us today.

I think our host, Dr. Daniel Lee, may very well have identified a framework within which to discuss problems such as these. In his book, Navigating Right and Wrong, Dr. Lee argues against "Mountaintop morality" in dealing with the difficult issues of the day. Those politicians and others who have easy answers are the "Mountaintop moralists." Dr. Lee eloquently argues why mountaintop morality will not work. He writes: "Our finiteness is such that there is no place on which we can stand and judge the whole world. 'Mountaintop morality' is invariably mistaken morality, at least in its form and structure, if not in its content. Rather, the nature

and substance of morality are best discovered on a horizontal plane - on the plain in the valley below as we live and experience interpersonal relationships that recognize and affirm the humanity of all of our fellow human beings." So my wish for the conference today is that we, from the valley of the Mississippi River, will avoid mountaintop morality - instead that we will ask how to affirm the humanity of our fellow human beings by addressing health care issues in a careful and thoughtful way.

Thank you.

AUGUSTANA COLLEGE

Accounting
Africana Studies
Anthropology
Art
Art History
Asian Studies
Biochemistry
Biology
Business Administration
Chemistry
Chinese
Classics
Communication Sciences & Disorders
Communication Studies
Computer Science
Creative Writing
Economics
Elementary Education
Engineering
Engineering Physics
English (Literature)
English (Writing)
Environmental Management & Forestry
Environmental Studies
Ethics
French
Geography
Geology
German Studies
Greek
Graphic Design
History
International Business
Japanese
Landscape Architecture
Latin
Library and Information Science
Mathematics
Multimedia Journalism & Mass Communication
Music
Music Education
Music Performance
Neuroscience
Non-Profit Leadership Development
Philosophy
Physics
Political Science
Pre-Dentistry
Pre-Law
Pre-Medicine
Pre-Music Therapy
Pre-Nursing
Pre-Occupational Therapy
Pre-Optometry
Pre-Pharmacy
Pre-Physical Therapy
Pre-Physician Assisstant
Pre-Seminary
Pre-Veterinary Medicine
Psychology
Religion
Scandinavian Studies
Secondary Education
Sociology
Sociology (Social Welfare)
Spanish
Theatre
Women's & Gender Studies