

P E R S P E C T I V E

Health Reform: Getting The Essentials Right

By addressing the essentials—coverage, cost control, coordinated care, and choice—policymakers can take important first steps toward health system reform, with details to be worked out along the way.

by **Victor R. Fuchs**

ABSTRACT: As the ninety-year history and failure of health care reform illustrates, it is easy for policymakers to disagree about the details of any new plan. In this Perspective, the author suggests trying a new approach this time: enacting a plan that encompasses four essential principles and then making midcourse adjustments later to get the details right. He defines the essentials as the Four Cs: coverage, cost control, coordinated care, and choice. [*Health Affairs* 28, no. 2 (2009): w180–w183 (published online 16 January 2009; 10.1377/hlthaff.28.2.w180)]

A COMMON phrase states that “the devil is in the details.” Many groups claiming to support health reform use this phrase when they wish to conceal opposition to substantive change—or establish their expertise in some small facet of reform. Doubtless, details are important. But as the debate proceeds, Congress and the incoming Obama administration must remember that “God is in the essentials.” Without the essentials, no reform plan can succeed. What are the essentials? They are coverage, cost control, coordinated care, and choice—the “Four Cs.”

The Four Cs

■ **Coverage.** First, truly universal coverage—100 percent of Americans—is essential. Pressure will intensify to settle for increasing coverage for one group or another. “Cutting the number of uninsured people by half” will be hailed as a great victory for reform. But leaving millions of Americans without coverage is not only unfair, it is also inefficient. The re-

maining uninsured people will still get some care, albeit haphazard and uncoordinated, and their care will still be paid for by the insured or providers.

Furthermore, Americans left out of the insurance pool are likely to belong to two groups: low-wage workers and healthy people in their twenties. It is unfair to leave out of the social compact Americans who work hard and pay taxes. Young, healthy Americans should not become habituated to being free riders. To demand that insurance companies guarantee issue and not exclude pre-existing conditions requires that everyone be in the insurance pool—including the young and healthy, who are cheap to cover.

Universal coverage can actually result in lower total spending because it can eliminate the high administrative costs that are now necessary to determine who is eligible for coverage and who isn't. Also, universal coverage facilitates the possibility of cost-saving changes in the organization and delivery of care.

Victor Fuchs (vfuchs@stanford.edu) is the Henry J. Kaiser Jr. Professor Emeritus at Stanford University in Stanford, California, and a research associate at the National Bureau of Economic Research.

■ **Cost control.** Politically, cost control is necessary because insured Americans will be more likely to support reform if it moderates the burdensome growth in their premiums and deductibles. It is also necessary because, as the Massachusetts experiment seems to be demonstrating, failure to control costs makes coverage gains unsustainable.

■ **Coordinated care.** Coordinated care is essential for both improvement in quality and elimination of unnecessary costs. Coordination requires some reform in how physicians, hospitals, and the entire health care system get paid and deliver care. This is especially true for management of chronic illnesses, which account for 75 percent of all health care spending.¹ Coordination produces wins in two areas: quality and cost. It can curb the excessive use of expensive high-technology interventions that are used inappropriately to produce little or no health improvement. Coordination that improves care for diabetes, congestive heart failure, emphysema, and other chronic conditions also can reduce or eliminate avoidable hospitalizations.

■ **Choice.** Finally, choice is a fundamental American value, and choice of insurance plans as well as networks of physicians and hospitals is essential for successful reform. Perceived restrictions on patient choice were used effectively in the “Harry and Louise” ads of the 1990s to help rally opposition to the Clinton reform proposal. Furthermore, for the many Americans who now have no choice of plans or providers, expanding choice could be an incentive to support reform.

How To Achieve The Goals

When we think of reform, we must think of what Congress can embody in legislation. But laws can't always mandate that these objectives will be achieved. For instance, Congress cannot mandate that physicians coordinate care with hospitals and other providers. Legislation can, however, change the incentives, infrastructure, and information systems to move providers toward greater coordination.

Let's examine how the Four Cs should be dealt with, one by one.

■ **Coverage.** There are two reasons why people don't have health insurance: They are unable to acquire it, or they are unwilling to do so. The first group (about three-quarters of all uninsured people) are too poor or too sick to get insurance without financial assistance.² The unwilling include young, healthy people who think they can do without coverage and others who “ride free” in the expectation that if they run up large medical bills, the system will take care of them.

The essentials for universal coverage, therefore, are subsidies for those who cannot acquire insurance on their own and requirements for those who are unwilling to do so. There are several methods for achieving these goals. For example, a combination of individual and employer mandates combined with generous subsidies will come close, as the Massachusetts plan is demonstrating. A single-payer “Medicare for All” approach will also do it, as demonstrated by the current Medicare program for those age sixty-five and older. And a universal voucher approach leaving people free to choose among competing health plans will also work, as demonstrated by the current Dutch and Israeli health care systems. Selecting among these methods should be based primarily on their ability to control costs and improve coordination of care.

■ **Cost control.** There is no single “magic bullet” for cost control. Multiple forces will have to pull in the same direction to restrain cost increases.

Entitlements and budgets. One of the essential means is to eliminate open-ended entitlements and create a defined budget for government-funded health programs. Such a budget will provide a strong incentive for insurers and health care providers to focus on high-value interventions and redesign delivery systems to improve efficiency and quality.

Technology/outcomes assessment. According to multiple studies, including most recently those of the Congressional Budget Office, development and diffusion of new technologies drive increases in medical care costs.³ There is growing agreement that the nation needs some kind of comparative assessment process and

increasing likelihood that this will soon be enacted. Such assessments are essential to inform both coverage decisions by health plans and treatment decisions by physicians. Most importantly, these assessments will signal drug and device manufacturers and procedure-oriented providers that interventions will be evaluated for coverage and payment based on effectiveness and cost. Today, pharmaceutical and other companies can charge top dollar for interventions that offer few improvements in quality of life and little additional survival.

Of equal importance is systematic outcomes assessment. Technology assessments typically rely on data from clinical trials with highly selected patients, but they cannot give an accurate picture on how tests and treatments work in “real life,” where they are used in combination with other tests and treatments for patients with multiple chronic conditions. A health information superhighway is an essential piece of outcomes assessment, and it seems to be part of President-elect Obama’s recovery plan. This infrastructure should be deployed in conjunction with a plan for the systematic collection of data. Combining information from medical records with information on drug usage, laboratory results, and payments can create a “real-time” national database on patient outcomes, the use of services, costs, and the use of technologies in the “real world.” This database should be open to all researchers who promise to publicly disseminate their methods and results. The data would facilitate pay-for-performance (P4P) and other methods for holding both insurers and providers accountable for the quality, cost, and efficiency of care.

Payment reform. We know the worst way to pay health care providers: fee-for-service. That is what we mostly do today. We do not know the best way to pay. And there probably is not a single best way. Hence, we need experimentation and innovation in payment, whether more P4P with bonuses for good performance, bundled payments, or partial or full capitation. To control costs, it is essential that payers have the freedom to experiment in rewarding value

rather than volume.

Competition. If insurers have to provide a standard benefit package with guaranteed issue and no pre-existing disease exclusions, receive risk-adjusted premiums, and have their outcomes monitored, they will have a strong incentive to change their business model from excluding sick patients to actually managing care for efficiency and value. This is how competition can work to control costs.

Sensitivity to cost and value. One way to make the public more sensitive to the cost and value of medical services is for people who want more services of small marginal value to pay with their own after-tax dollars for coverage that is above the standard benefit package. For example, wider selection of physicians or hospitals should require a supplemental fee. A complementary approach is using value-based insurance so that patients face higher copayments for more expensive services when cheaper interventions are just as effective, or when the indications for the tests or treatments are more tenuous.

There is no guarantee that these measures working together will restrain costs, but they have a better chance than any other approach—especially efforts to simply lower unit reimbursement to providers.

■ **Coordinated care.** The health care system is a fragmented, nineteenth-century cottage industry in which fee-for-service payment inhibits coordination. Payment reform that rewards coordination and patient outcomes should improve care. Similarly, a national database for outcomes assessment would provide data to rapidly refine guidelines and transform them into physician reminders and templates for ordering tests and treatments. Such a database would also help identify which providers are achieving good patient outcomes and how they are doing it.

Perhaps most important, legal and regulatory reform is essential. There are a myriad of laws that inhibit the financial and administrative relationships among providers that are essential to clinical coordination. For instance, “Stark II” self-referral prohibitions and the federal antikickback laws are meant to ensure

that patient care decisions are based on medical need, not providers' financial interest. These rules are overly broad. While prohibiting self-enrichment, they also inhibit financial incentives to facilitate the collaboration between physicians and other medical providers that improves coordinated care for patients with chronic conditions. They need to be amended, and safe harbors more uniformly defined, to permit closer financial, administrative, and clinical relationships between physicians and hospitals. As suggested by Timothy Jost and Ezekiel Emanuel, establishing a Commission for Innovation in Delivery Systems in the federal government to provide rapid "one-stop" review and authorization of proposals for new payment and delivery system arrangements could facilitate essential innovation.⁴ Antitrust and tax laws also need reform to permit combinations that facilitate the coordination of care.

Obviously, there needs to be oversight to ensure that these links improve the quality of care, rather than merely serving as a cover for provider enrichment. Similarly, reform of scope-of-practice laws is essential to permit the more-flexible use of advanced practice nurses and other health care professionals, especially in the primary care setting.

Many providers also want tort reform. Although that would probably not have a significant impact on health care delivery or cost control, it is highly desired by physicians and would be helpful in securing their support for a far broader reform plan.

■ **Choice.** Choice is a desirable feature of any reform proposal. The public values choice as a good thing in itself because it confers a sense of power and control. Also, choice is essential to control costs through competition. But too much choice can be counterproductive in health. If the range of choice in insurance is unlimited, insurance companies can manipulate differences in an attempt to cherry-pick. To maintain equity and avoid adverse selection, some limits on choice are necessary. With regard to the organization and delivery of care, some restrictions on choice may be necessary in the interest of quality and cost. For exam-

ple, "any willing provider" laws can inhibit the formation of more-efficient medical groups.

ANYTHING THAT substantially changes 16 percent of U.S. gross domestic product will necessarily be complex. It is easy to disagree about the details of any plan. Failure because of such disagreements is always the easiest course, as the ninety-year history of health reform has demonstrated. But policymakers should keep the focus on the essential objectives and means. They must recognize also that reform of anything as complex as health care will not be perfect the first time. Unintended consequences will occur, and intended consequences will fail. Enactment of the essentials with a flexible framework that permits easy midcourse corrections and adjustments can, by successive approximation, get the details right.

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NOTES

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2. P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey," EBRI Issue Brief no. 321, September 2008, http://www.ebri.org/pdf/briefspdf/EBRI_IB_09a-2008.pdf (accessed 6 January 2009).
3. See, for example, Congressional Budget Office, "Technological Change and the Growth of Health Care Spending," January 2008, <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf> (accessed 6 January 2009); and Peter Orszag, CBO, "The Long-Term Budget Outlook and Options for Slowing the Growth of Health Care Costs," Testimony before the Senate Finance Committee, 17 June 2008, http://www.cbo.gov/ftpdocs/93xx/doc9385/06-17-LTBO_Testimony.pdf (accessed 6 January 2009).
4. T.S. Jost and E.J. Emanuel, "Legal Reforms Necessary to Promote Delivery System Innovation," *Journal of the American Medical Association* 299, no. 21 (2008): 2561-2563.