
Total Cure

The Antidote to the Health Care Crisis

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Preface

The crisis in health care will not be solved with two aspirin and the hope we'll be OK in the morning; instead we need to restructure the system fundamentally. That is what *Total Cure* is about. Reform of the American health care system has been a recurrent issue for decades. Over those years the proportion of the gross domestic product devoted to health care has grown while the proportion of the non-elderly population with coverage has shrunk, and those trends are increasingly recognized as being unsustainable. The last major attempt to reform the system—in the beginning of the Clinton administration in the 1990s—failed to garner the necessary political consensus. A new administration taking office in 2009 with the baby boomers approaching the age of Medicare eligibility makes the time ripe for serious consideration of change.

In mid-2004, when I first considered this undertaking, these issues were obvious, as was the high likelihood that many proposals would be forthcoming from academics, policy analysts, and politicians. The question was whether I could contribute something to that discussion. For over three decades my focus had been on empirical work in understanding how the health care system functions, including topics ranging from competition to outcomes measurement, from hospitals to HMOs, from storefront clinics to high-tech equipment. Through all these investigations, this remained true: the deeper one

dug into the question at hand, the less obvious were the answers. The usual analytic tools often addressed only part of the problem, and frequently there were multiple valid perspectives. Stakeholders were rarely evil but were operating within constraints and dealing with incentives they could not control. People used the same words for different concepts and misunderstood one another.

Those lessons could have been the basis of a book for my academic colleagues and future generations of researchers. The directions of the new reform proposals, however, offered another and more important opportunity. Nearly all the proposals focus on the growing problem of the uninsured; some give what I think is only superficial attention to containing health care costs. None really consider a thoroughgoing restructuring of the payment and delivery system. Simply ensuring that everyone has coverage will not change the problems we have with quality of care, insensitivity to patient preferences, overly bureaucratic systems, lack of professional autonomy, or rapid growth in costs.

Nevertheless, restructuring payment incentives, making information available in new ways, taking advantage of changes in medical specialization and inpatient care, and empowering patients can result in a system that addresses those underlying concerns while ensuring coverage for all and rates of growth in cost that are more acceptable than we now project. Thus, what had initially been a conceptual and “teaching” piece was transformed into a policy proposal. The academics could wait: the public deserved a new approach to be placed on the table for the ensuing policy debate.

As I write this in February 2008, it is still not clear who will be the candidate for either party, let alone the winner in the presidential election. This does not really matter, however; the problems we face affect us all. Moreover, the solutions I offer include features that should be attractive to both the right and the left. The public and the politicians have recognized that global warming is occurring regardless of the rhetoric used, and we need to apply a broad range of tools to deal with it. Likewise, we must recognize that improving the value

our health care provides is no longer just a campaign slogan but an imperative, and we must think differently about how we move toward such improvement. I do not imagine that my proposal will be *the* answer, but I hope it begins a discussion that moves us to one.

The Robert Wood Johnson Foundation deserves much of the credit for this book. It provided direct support through an Investigator Award in Health Policy Research. More important, I have been involved in the Foundation's postdoctoral programs for over three decades and consider myself a thirty-fifth-year post-doc. Literally hundreds of fellows, with backgrounds ranging from medicine and nursing to ethics and political science, from economics and statistics to anthropology and sociology, from neonatologists and gerontologists to social workers and lawyers, have educated me while I was purportedly teaching them.

The Center for Advanced Study in the Behavioral Sciences provided the perfect setting for a sabbatical in 2006–7, when much of this book was developed. The isolation from the routine academic and administrative chores and the rigorous intellectual engagement from the staff and fellows at the Center created the optimum environment for creativity. The excellent advice I obtained there shaped much of what follows.

My colleagues at the Philip R. Lee Institute for Health Policy Studies (PHI-IHPS), the University of California at San Francisco, and the Palo Alto Medical Foundation Research Institute (PAMFRI) have been wonderful in adapting to my being distracted from day-to-day responsibilities. Special thanks are due to Eunice Chee, who, behind the scenes as always, keeps everything running smoothly.

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Laura J. Eaton, M.D., M.P.H., has been my collaborator in the empirical work on episodes of care that supports the plausibility of the proposal. Amy J. Markowitz, J.D., provided her expertise as an editor to help shape the manuscript into a readable form. Beth Newell came to this project a year out of college and after a week on the job had eviscerated a précis of mine. Her ability to “speak truth to power,” question assumptions, offer suggestions, and track down material is truly awesome. Without her there would have been no book.

I thank Harvard University Press, and especially Michael Aronson, who believed in this book and helped it see an early publication. Amanda Heller provided expert editing with a light but instructive hand. Of course, any errors, misconceptions, and obscurity that remain are my responsibility.

I owe a special thanks to my children, Shira, Chad, and Jana, and particularly to my wife, Lori. She has been unfailingly supportive through this process, sitting through far too many repetitions of the ideas, waiting while I did just a bit more writing, and forgoing too much attention. I thank them all.

Introduction

Health reform has reemerged on the nation's agenda. By late 2007 it had become the top domestic issue. Whether Democrat or Republican, every candidate put forward some ideas. Given electoral politics, however, it is not surprising that the proposals were often long on rhetoric and short on specifics. The experience of the Clintons in the early 1990s demonstrated the risks of being too specific before aligning the political consensus that is needed to pass legislation.

The major issues being discussed are the ever-increasing expenditures on health care, the rising cost for employers, and the falling proportion of people with insurance. In the background, and barely hinted at, is the impending burden on Medicare of the baby boomers, the first of whom will be eligible for coverage before the end of the new administration. Not surprisingly, Democrats focus on ways to reduce the proportion of those without insurance, if need be with tax increases. Republicans eschew tax increases but seem willing to discuss expanding coverage as long as it occurs primarily via the private sector.

More problematic than this ideological division, however, is the failure of both camps to look beyond coverage to more fundamental problems in our system. People *with* health insurance find the system bewilderingly complex. The Institute of Medicine, the Rand Corporation, and others have repeatedly demonstrated that quality of care

is far from what it should be. Patients are unnecessarily harmed by their encounters with the health care delivery system. Physicians and patients increasingly find the practice of medicine rigid and depersonalized. New technologies and drugs are announced weekly with much fanfare; many are later found to be more costly and to deliver far less than promised. “Old technologies,” some as simple as routine hand-washing or careful listening to the patient’s problem, are underused.

Health insurance is too often the goal of policy, yet it is merely a tool to get people the care they need, when they need it, at an affordable cost. Some innovations are thought to provide solutions. Electronic health records can certainly help, but few discuss what incentives clinicians will have to bear the costs of entering data and using the information such records can provide. Evidence-based medicine is certainly better than anecdote-based medicine, but fewer than half of well-researched quality measures are attained in practice. The techniques may be available, but much more needs to be done to translate them into practice.

Most health reform proposals fall into one of two groups. The first group attempts to increase the number of people with health insurance obtained through the patchwork of employer sponsorship, individual enrollment, and government programs. Leaving intact the existing fragmented system, such proposals need to find the money to subsidize private coverage or expand public programs, typically through some combination of tax increases and promised savings through prevention. The middle class, however, is unlikely to support increasing its taxes to pay for more coverage for the poor when the system does not work well for even those who have coverage. Prevention may improve health, but there is little solid evidence that the promised savings in reduced costs for chronic illness will appear anytime soon.

The second set of proposals envisions a single-payer, tax-financed system for everyone. Its proponents argue that while taxes will increase, overall expenditures on health care will slow because of sav-

ings that are sure to come from a unified system. The current fragmented financing system does have enormous administrative costs, but only some of these would disappear with a single-payer system. Single-payer advocates, moreover, rarely offer details about exactly how such a system would operate. In addition to the political resistance to tax increases, there are real questions about how the government would operate the system.

Neither set of proposals addresses the fundamental questions of how health care delivery should be reoriented to assure everyone high-quality care at reasonable cost. Proposals in the first group assume that the existing structure of insurance will somehow do this, despite its abject failure thus far. There is no reason to believe that increasing deductibles or building information systems will magically provide the answer. Similarly, the challenge to the single-payer advocates is to describe realistically how the administration of the new system will decide which hospitals will be closed, what procedures are unnecessary, and how fees should be set.

The approach in this book avoids the simple answers of political rhetoric. It explicitly addresses the more complex task of determining how to make the health care system work better, rather than just how to finance more of the same. Instead of focusing on getting to universal coverage while leaving the issues of long-term cost to vague promises, it focuses on how the system should be restructured to improve care for everyone. It gives providers the freedom they desire to practice and set fees but holds them more responsible for the decisions they make. Better information is needed; and with new incentives, clinicians will demand information to achieve better outcomes at lower cost. Government should make sure that the underlying data are freely available. Care will be delivered not in regimented, cookie-cutter fashion, as some allege will happen with a universal system, but in a highly individualized manner responsive to patient preferences and values. The new system will not guarantee that costs will be contained; no system can guarantee that without being willing to sacrifice quality. The new system will guarantee, however, that indi-

vidual patients and the public collectively feel they get value for the money they devote to health care.

With all of the efforts of policy analysts and health economists over the decades, why should one give credence to a proposal promising far more than the best teams have offered thus far? My answer is that I began with a different question—*how to improve care* rather than *how to improve coverage*—and focused on a different approach: on realigning incentives for all the participants in health care rather than on raising enough money to continue operating the old system.

Medical expenditures include rare but very expensive events that involve uncertainty about how to care for them. People want insurance to cover the costs of care they may need; clinicians do not want to bear the financial risk of providing all the care patients may require. The reimbursement-based insurance we currently have addresses these demands, but in ways that eliminate incentives for patients and physicians to think carefully about the choices they make. The insurance carrier determines what services it will cover and what rates it will pay providers—physicians, other clinicians, and hospitals. It utilizes financial incentives such as deductibles and coinsurance to reduce patient demand, combining these blunt tools with occasional decisions about whether to pay for certain services in specific instances. Attempting to contain costs by reducing fees seems to lead physicians to increase the use of services for which they can charge extra, hence raising overall costs. In our current model a third party—neither patient nor physician—decides whether and how much to pay for a disconnected series of services.

Illnesses and injuries, however, occur in real people who have to decide whether to seek care. Clinicians make complex decisions about what is needed to treat the patient, marshalling a wide range of resources—their own and others’—to achieve the best possible outcome. Instead of a disconnected stream of services, think of those services as collected within episodes of care—just as patients and clinicians think of them. Payment should be structured to give patients and physicians the appropriate incentives and information to assess the value of various choices they need to make. People should have

many choices in the care they receive and the costs they are willing to bear. People should not, however, have the option to forgo coverage. The uninsured, healthy twenty-year-old can suffer a catastrophic injury, and because we do not let people without coverage die on the streets, we end up paying for his care. Once people develop chronic conditions, they become uninsurable at reasonable cost. Those who choose to be uninsured typically regret not having insurance when they need care for major events; society must ensure that all are covered for such events. Coverage for other health needs is more discretionary; the public role in paying for those needs reflects equity and public health concerns. A just society makes certain that its least well-off members have either adequate income or assurance of basic food, housing, education, and health care needs. A society desirous of being healthy makes sure that income constraints do not deter people from preventing costly illnesses.

The plan I propose, SecureChoice, has two major components. The first is a universal coverage pool (UCP), encompassing the major risks of hospitalization and chronic illness for which everyone should have secure coverage. This pool will ensure financial access to all the services needed for such episodes of care, paying the average cost of the services needed to deliver superior outcomes. Physicians and hospitals will have both the incentives and the flexibility to deliver high-quality care efficiently. All will be in the same pool, never needing to worry about losing coverage or facing escalating premiums because they have fallen ill, their employer reduces benefits, or they change jobs. Some may be concerned that the absence of patient-based incentives will increase costs. Our current system, however, shifts costs to patients with little control over decisions in the hospital and offers no incentives for physicians to be more cost-conscious. The new episode-based payments combined with clinician-driven demands for improved quality measures will markedly increase efficiency. The UCP addresses only a quarter of the problems that bring people into contact with the medical care system, but these problems account for almost two-thirds of the cost.

The second component of the proposal emphasizes choice, flexi-

bility, and responsibility. Plans will not constrain people in their choice of a physician to be their “medical home”—to keep track of their health records, provide much of their primary care, and offer referral information. Each physician will choose one entity—a former health insurer, credit card processor, or any other organization good at handling financial transactions—to be a payment intermediary (PI), handling all the claims for his or her patients. By processing claims, the PI automatically collects the data needed to price premiums. These premiums are essentially the ambulatory care costs incurred by that doctor’s patients net of the payments received from the UCP based on their chronic illnesses. The PI can develop and offer a wide range of co-payment options from which the patient may choose. Physicians can set their own fees, practice styles, and referrals, knowing that the incremental cost implications of such choices will be borne by their patients. Some physicians will seek information on how others provide comparable-quality care at lower cost; others will demonstrate to their patients that they offer higher quality, more responsiveness, or increased satisfaction.

SecureChoice offers security for all people. All will be in one major risk pool regardless of employer and can access the UCP at the same rates even if not employed. Even if SecureChoice is not financed fully through taxes, the premium charged by the UCP will not differ on the basis of health status or use of services. Incentives to be efficient in treating major illnesses are placed on physicians and hospitals—not patients. The universal coverage pool pays enough to cover the costs of care needed by those providers who achieve superior outcomes.

SecureChoice is not about cost containment; it is about value in health care. “Cost containment” is terminology used by governments and employers wanting to keep their expenditures down, typically by squeezing provider payments and shifting costs to patients. With SecureChoice, if superior outcomes cost more than worse outcomes, the pool will pay more. Numerous studies in the United States and elsewhere reveal that medical care is far less efficient than it can be; appropriate treatments are often neglected, and unnecessary inter-

ventions are often delivered. SecureChoice includes incentives and makes available the data for clinicians to learn how to improve practice continuously so as to offer better outcomes at lower cost. In the long run, SecureChoice will lower the rate of growth in health care spending. Whether the health care share of gross domestic product rises or falls matters far less than whether we achieve the best health possible for that expenditure.

SecureChoice provides far more patient choice than even voucher-based systems, let alone plans designed by employers for their employees. People can choose their own physicians. Physicians will offer a wide range of payment options—from high deductibles to first-dollar coverage—and patients will choose the physician and payment arrangements best matching their preferences. Patient costs vary, but because of the effects of different financial incentives and the physician chosen, *not* because of the patient's chronic illnesses; the UCP offsets those costs. Members of a family can choose different doctors with differing co-payment arrangements; these choices can change over time as circumstances and preferences change.

SecureChoice allows clinicians to be the best professionals they can be. Payment structures and fees will be set not by government or health insurers but by individual physicians. If a doctor wants to provide forty-five-minute office visits, telephone consultations, or e-mail advice *and* charge for those services, that is perfectly fine. Primary care physicians will be able to refer patients to whomever they choose. Physicians will decide which payment intermediary will assist them in handling their patients' claims, choosing the one that does so with low administrative costs and hassles, and provides them and their patients with valuable information. With all this flexibility comes an appropriate degree of responsibility. Physicians who increase their fees without learning how to use other resources such as tests, scans, and new pharmaceuticals more efficiently may find that the increasing premiums passed on to their patients result in pointed discussions when patients decide whether to stay with that physician the following year.

SecureChoice will make available to clinicians, hospitals, and pa-

tients far more information than is currently the practice. Electronic health records may eventually make this easier, but at the outset the data will come from claims and other information generated in the normal care and payment processes. Instead of data being “owned” by health plans, however, SecureChoice pools all the data in a confidential manner. Converting data into useful and actionable information is not easy, but clinicians and hospitals will have strong reasons to demand such information, and independent analysts will respond. Accessible data and transparent methods will keep special interest groups from inappropriately influencing care and payment.

SecureChoice relies heavily on market incentives both to enhance flexibility *and* to reduce the power of corporate interests. Powerful interest groups often use “free market” ideology to protect the status quo while wielding power through the Congress and regulatory mechanisms. In contrast, SecureChoice includes a relatively small role for government. The UCP is managed by a semi-independent agency insulated from Congress and the executive branch. Its role is largely to pool resources, determine future premiums, and ensure that data are accessible. The payment intermediaries process claims but do not “own” patients or clinicians.

SecureChoice recognizes the importance of technological innovation in health care. Pharmaceutical companies will do what they should do best: develop new drugs. Experimental drugs will be made freely available through trials; all other drugs are implicitly included in covered benefits. Individual physicians, however, will decide which drugs to prescribe, judging when the new and more expensive ones are worth the extra cost. In making such decisions, they will ask for and receive independent assessments of what seems to work best in what circumstances. As new technologies come into use, as physicians make treatment decisions, and as the data systems follow costs and outcomes, all will learn when new technologies should be utilized.

SecureChoice is designed to be a comprehensive system, but transitions take time, and some people may never want to change. An

important aspect of SecureChoice is that it moves away from making employers responsible for the funding and sponsorship of specific health plans. Depending on what policy choices are made for funding SecureChoice, employers may still be the source of much of the money that flows into the system. Some may quickly “cash out” their current contributions; others may transition slowly, using the UCP first to pay for efficient hospital care and perhaps later to handle all of the major risks for their enrollee group. At the same time, employers may focus on creating health-promoting environments and incentives for their workers and communities.

SecureChoice does rely on government in a few key areas. Safe drugs and devices will continue to be assured by the Food and Drug Administration (FDA). Fair market practices will continue to be assured by those enforcing antitrust laws. The federal, state, and local governments now pay for health insurance for the poor through Medicaid and the State Children’s Health Insurance Program (SCHIP), and pay for or provide care through various safety net programs. SecureChoice envisions an income-based subsidy program that reduces the premium and out-of-pocket costs for all low-income people. This subsidy occurs behind the scenes; from the perspective of providers, everyone in SecureChoice yields the same fees. Access for the poor will improve markedly, but some safety net programs will still be needed in select geographic areas and for people for whom simply providing insurance coverage is not enough to ensure that they will get the care they need.

SecureChoice is not a formal legislative proposal but a sketch for one that might be developed in the next few years. It recognizes that fundamental changes in how we spend a sixth of our gross domestic product will be intensely political. Thus all the current players can have roles in the new system. In many instances the roles will be quite different from the present configuration, and some entities within groups may succeed even if their group loses power. For example, health insurers will no longer be center stage. Shedding their role as villains, however, insurers can use their expertise to offer physi-

cians valuable services as payment intermediaries and as converters of data into useful information. Determining exactly how to craft a legislative proposal and build the necessary public consensus to enact something like SecureChoice is beyond the scope of this volume. The goal of this book is simply to lay the foundation for such discussions.

One challenge in moving forward is that most people think about health reform in one of two ways. Some want to adopt a system that appears to be working well in some other country—although every nation is facing its own problems. Others want to keep what we have and just make marginal improvements. SecureChoice is not a wholesale adoption of other models, nor is it minor tinkering. Instead it is a fundamental rearrangement of what exists in the United States, building on our strengths and sidestepping our weaknesses. Such a shift in thinking is not easy; if it were, we would have come to it long ago.

In Chapter 1, “Build on What You’ve Got, but Recognize Real-World Constraints,” I explain why we cannot simply adopt the health care system of any other nation and why minor changes to our current system will not address our core problems. Chapter 2, “Overview of a Restructured Health Care System,” provides a more in-depth summary of SecureChoice than in this introduction. It gives the reader a sense of the issues that will be addressed in detail in each of the successive chapters. I then give the rationale—economic, political, and value based—for the proposal. I do this because not everyone will agree with all aspects of SecureChoice, but areas of agreement should be identified whenever possible. If disagreements can be resolved by getting better data on underlying facts or behavioral factors, we should gather that information. If disagreements arise from values, we should see if compromise is possible.

Chapters 3–6 focus on the details of how SecureChoice is structured and the rationale for those design details. The discussion begins with Chapter 3, “Covering the Cost of Care: Rethinking Health Insurance,” focusing on the two main aspects of the plan: (1) the universal pool to cover major acute/interventional (MA/I) care and

chronic illness management (CIM) care, and (2) the patient- and provider-based premiums that will facilitate coverage and payment for minor acute and preventive care. Chapter 4, “Organizing Care and Paying Providers,” focuses on the payments and incentives for clinicians and organizations delivering health care. A key aspect of SecureChoice is that it achieves many of the beneficial incentives that are possible within integrated delivery systems without requiring physicians to change markedly where and how they deliver care. Chapter 5, “Choices: Harnessing Data to Inform Decisions,” describes how the new system will collect data to inform choices by clinicians and patients. Chapter 6, “Financing SecureChoice,” describes financing alternatives. The simplest would be a fully tax-funded system, but because that may be politically difficult, I describe how one could build on existing financing mechanisms. A fully tax-based model implicitly guarantees equity, but one can achieve any degree of equity with a tax-funded, income-based subsidy program. Either approach would be a marked improvement over what we have now.

The last three chapters step back from the details. Chapter 7, “Malpractice, Pharmaceuticals, Medical Education, and Prevention,” sketches approaches to address four key problem areas that will impinge on or can benefit by being integrated with SecureChoice. The fear of malpractice is often used today as a rationale for what is otherwise unnecessary care. SecureChoice gives physicians and hospitals much more flexibility in how they organize and deliver care and incentives to become more efficient. Unless the current fear of malpractice suits is offset, however, innovation will be slowed. Chapter 7 outlines a proposal offering better compensation for patients injured by their medical care experiences *and* reduces allegations of negligence. It simultaneously provides new roles for malpractice attorneys to reduce avoidable errors by pressing organizations to improve their systems of care. SecureChoice encourages and empowers physicians to assess critically whether expensive new drugs and devices provide enough benefits to justify the additional cost. Pharmaceutical firms and others will have to price and market their products dif-

ferently, and there is a concern that this may reduce investment and research. SecureChoice can provide investment and market risk reinsurance approaches to keep innovations flowing. The medical education “pipeline” is even longer than the drug pipeline; we need to incorporate changes early to ensure the right mix of physicians. SecureChoice focuses on rebuilding the health care system, but much of what affects health lies outside of health care. Policy changes should be considered to enhance long-run behavioral and environmental factors in order to allow our population to be healthier and require less medical care.

Chapter 8, “How SecureChoice Would Work for Patients and Physicians,” uses patients Harvey and Louisa and their physicians to show how SecureChoice would function. Chapter 9, “Getting There: Policy Choices, Implementation, and Transition,” takes us back to the present, with a discussion of the issues that must be addressed if we are to move toward a rebuilt and better-functioning health care system for all.

The SecureChoice proposal outlines a comprehensive restructuring of American health care, a system of enormous complexity. SecureChoice is much simpler than what we have now, but nevertheless has many components and uses incentives and structures in markedly different ways. Achieving an understanding of SecureChoice is difficult if readers try to assess aspects in the context of the current system, or are unwilling to wait for information that comes later in the book. I cannot promise that every question will be answered by the time one reaches the last chapter, but many of the concerns that arise early on will be addressed. The questions and issues that remain should serve as the basis for more fruitful discussions about how to truly improve health care.

— 1 —

Build on What You've Got, but Recognize Real-World Constraints

Our health care system is like an old house that has been modified multiple times over the years but no longer meets the owners' needs, is inefficient, and appears to be falling apart. Patching holes, buying new appliances, and making minor redecorating changes is one option. Tearing down the whole structure and replacing it with a new building modeled on what appears in *Architectural Digest* is another option. These alternatives represent the primary approaches to addressing our health care system's problems. Some propose only to tweak the existing system by expanding coverage to a specific population subgroup or relying on information technology to solve shortcomings. Others feel that the solution is to scrap the current system and adopt what is in place in another country, be it Canada, France, or Germany.

Neither approach addresses problems arising from the details of how a health care system works: how care is organized and delivered, what patients want from medical care, and what clinicians need in order to practice their professions. To propose system change, however, one must recognize fundamental laws, history, and values that are not easily altered. The U.S. constitutional system differs from parliamentary systems. Americans cherish the image of the rugged individualist for whom the watchword is "That government is best which governs least." This book will not explore other nations' systems. For

decades advocates have argued for the adoption of various foreign models; the political challenges surrounding change are so complex, however, that any “import” will be doomed. Just as an architect works within the physical characteristics and legal constraints of a site, health policy analysts must work within larger cultural and political constraints. Thus we begin by looking at what works well and what doesn’t; at what is given and what is not.

What (If Anything) Works Well

The list of things that don’t work (or appear not to be working) properly in our health care system is far longer than the list of things that function reasonably well. It is worth beginning, however, with those aspects most would want to retain.

Rapid and Wide-Reaching Technological Innovation

Americans value the pace, breadth, and dissemination of technological development and innovation in medical care. Innovation, however, may threaten the markets of existing players; this situation is not peculiar to the health care sector, as the transformation of airlines, mainframe computing, and telecommunication attests. Patients need to be assured that they are not being put at undue risk by new drugs, devices, and procedures. Under the guise of promoting safety, however, a highly centralized review and approval process may be co-opted by current market leaders to prevent the entry of competitors.

The widespread availability of technology and specialty-trained physicians means that rationing or queuing is rarely an issue in most parts of the United States—as long as one has private insurance or Medicare.¹ Put another way, patients don’t perceive services as being rationed in the sense of wanting and being able to afford them but not being able to get them. The fear that one might not receive potentially life-saving care because of some bureaucratic process is a

recipe for political disaster. Lobbying by patients led to mandating coverage of autologous bone marrow transplants for breast cancer in the absence of evidence of its efficacy; research eventually showed the treatment to be harmful and of no benefit.²

Clinical and Patient Autonomy

Clinicians generally believe that they can do whatever they feel is necessary for their patients. When managed care plans attempted in the mid-1990s to control utilization tightly, the ensuing backlash led to a reversal of such efforts. This laissez-faire approach to “practice style” means that geographic differences in patient preference and clinician practice are tolerated and go largely unchallenged, even without evidence that more care is better. All of this is consistent with the strongly held American value of individualism.

Individual values play out in complicated ways, especially when medical care intersects with religion. In some instances the government requires the availability of services some consider controversial, while in other instances it precludes their availability. Courts have ruled that employer-based plans may decide whether or not to include prescription drugs in their benefit packages, but if they choose to do so, a state may mandate that such coverage include contraceptives even if the employer objects on religious grounds.³ Federal programs, however, have been prevented by law from paying for abortions and certain other services because those services are objectionable to certain segments of the population.⁴

Reliance on the Private Sector

Reflecting another American value, the direct role of government is currently relatively small, or at least is kept in the background. In spite of the high quality of care now delivered within the Veterans Affairs (VA) system, there is almost no interest in having the government serve as a direct provider of care. The private sector dominates,

except in financing programs for the elderly and poor and some rural communities. Within both the Medicare and Medicaid programs, services are delivered primarily by independent providers, and the administration of claims is generally subcontracted to private entities. In part this is due to a historical preference for “small government.”

What Doesn't Work Well

Many aspects of the health care system do not work well, ranging from the high proportion of uninsured to the high cost of care, from unsafe care to malpractice litigation, from overly restrictive pharmaceutical formularies to advertising for unnecessary treatments. Some advocates for change focus on just one or a few of these issues. A narrow focus, whether because incremental change is preferred or to protect certain interests by deflecting attention, fails to address the other issues. Incrementalism has not been effective in the past.

A comprehensive approach, while seemingly more daunting, may actually hold far more promise. From a political perspective, the threat of one type of change may be offset by the promise of another. Tying the two together offers greater potential for compromise. From a technical perspective, a change may be too costly if undertaken for a single purpose but worthwhile if multiple goals can be achieved. It is helpful to place all the problems on the table and then see whether they can be addressed together. The list of problems is unfortunately long, but reviewing it offers a glimpse of the opportunities for change. Most discussions begin with concerns about the large proportion of people without coverage and then go on to suggest ways to expand coverage. Such reforms build on a fragmented system that is both costly and inequitable. Much of the discussion, moreover, focuses on what should—or should not—be included in the benefits package. Those discussions ignore the incentive problems in the current system as well as the administrative costs of operating it. This leads to a consideration of problems in the delivery of care: vari-

able quality, inadequate safety, and insufficient rewards for primary care, as well as the feeling common to clinicians of being deprofessionalized. Finally, most analysts see the long-term cost of the system as being driven by inexorable technological change.

The High Proportion of People without Coverage

Almost every discussion of health systems begins by citing the high proportion of Americans who lack health insurance coverage—currently about 16 percent and seemingly rising every year. Some view this with moral outrage, some with embarrassment, others simply as an unfortunate characteristic of the system, believing that most alternatives would be worse. Few argue that having so many without health insurance is desirable per se, as some believe, for instance, that the threat of unemployment creates valuable work incentives.

Even apart from the moral question of whether our society should ensure some basic level of coverage and the political question of whether leaving so many uninsured impairs our moral credibility among nations, there are other reasons for moving toward universality. Financing safety net care for people without insurance coverage through a patchwork of tax-supported public providers, shifting costs to other payers, and offering ex post facto eligibility for coverage in programs such as Medicaid is economically inefficient. These approaches also result in fragmented and poor-quality care. On those grounds alone, substantial change is warranted.

The High Cost and Inequity of Current Approaches

The majority of Americans (59.7 percent of the population) are insured through private health care coverage obtained through employers.⁵ Unlike the system of employer contributions in western Europe, where the cost is often a simple percentage of wages, the U.S. system relies on the employer to negotiate the specific insurance package, enroll workers and sometimes their families, and decide

how much to contribute. Most economists see the employer share of this coverage as part of the total compensation package; they believe that employers are indifferent as to whether compensation is paid as wages or as health benefits. A payment toward health insurance premiums, however, is quite different from the equivalent amount as a surcharge to wages. Health insurance coverage is “lumpy”—that is, an employee is either eligible or not—and the contribution is usually the same for each eligible worker. This contribution is a larger fraction of total compensation for low-wage or part-time workers, creating strong incentives to limit eligibility for coverage or to use “independent contractors,” who are not eligible for benefits.

From the employee’s perspective, the presence or absence of employer-sponsored health coverage may affect job mobility. Group policies are typically much less expensive than comparable individual coverage, and they average risk across everyone in the group, making coverage much more valuable for high-risk persons and relatively less valuable for low-risk persons. Employers recognize this, and some attempt to reduce the cost of their employee pool by attracting low- (or avoiding high-) risk workers.⁶

About 9.1 percent of the population is covered through individual policies.⁷ In theory, individual policies better meet personal preferences and needs, allowing some people to choose limited coverage while others may pay more for a broader range of benefits. Insurers’ flexibility in designing policies, however, is typically limited by state mandates. Marketing, underwriting, and other aspects of selling and administering individual policies add to their cost. Flexibility and choice do not come for free; these “load factors” widen the spread between the care paid for by the plan and the cost to the enrollee.

Individually purchased coverage may be eligible for some income tax deductibility; all of the employer’s contribution for coverage, however, is excluded from both income and payroll taxes. Such tax incentives are more valuable for those in higher income brackets, making them an inequitable way to provide coverage. There are also equity issues for employers. Older, more experienced workforces may

be more productive and warrant higher levels of compensation, but productivity does not rise as rapidly with age as do health care costs. Employers with continuing contractual responsibilities for retiree health benefits carry the contribution burden for people whom they no longer employ.⁸

Deciding What Should Be Covered

Policy analysts usually focus on specifying which broad categories of services health insurance should cover, such as inpatient care, ambulatory care, drugs, and devices. All such coverage is typically made subject to a determination of medical necessity. At an operational level, numerous decisions have to be made about whether specific services will be covered in specific instances. For example, MRI scans can be enormously valuable in many cases, but they provide no useful information—and sometimes result in harm—in others. A benefit package does not make this determination except by linking coverage to “medical necessity.”

As new procedures, devices, and drugs become available with increasingly expensive price tags, these day-to-day coverage determinations are progressively more important. Advocates for guaranteed coverage of specific services include patients who think they might benefit (and who may be desperate because there is no good alternative), as well as providers and manufacturers with a financial interest at stake. (The latter often give support—sometimes covert—to providers and advocacy groups.) Payers often resist efforts to expand coverage, in part because their premiums are fixed in the short run, and in part because increases in premiums further erode the voluntary purchase of insurance. Arguments over coverage mandates fought in the legislative arena are frequently determined not by scientific evidence concerning the benefits and costs of the interventions but by the political clout of the advocates on either side.⁹

The current patchwork of state regulation of most private coverage, federal determinations for Medicare, and the exclusion of

employer-administered plans from regulation creates multiple settings in which these coverage arguments are aired. A restructured system should address how such determinations are made, with the goal of increasing rational decision making and allowing the system to learn from natural “experiments” as well as randomized trials.

Ineffective or Problematic Incentives

There is substantial evidence that economic incentives influence consumer demand for health care. More questionable, however, is whether the current structure of co-payments and deductibles influences patient and clinician decision making in ways that are optimally affecting health. Deductibles clearly impact the initial decision to seek treatment, but they affect appropriate as well as inappropriate care. The general populace is not skilled at discriminating between relatively inconsequential health concerns and those needing evaluation by a clinician—an indication that medical training has value. High-deductible plans may create too much cost-based reluctance to seek care, although some preliminary results indicate otherwise.¹⁰ The current evidence is too fragmentary, however, for an accurate assessment of this issue.¹¹

A fundamental aspect of medical care, moreover, makes reliance on patient-based incentives unwise. Medical care expenditures are highly concentrated in a small proportion of the population. Typically, fewer than 20 percent of all people in a given population account for over 80 percent of expenditures (with 5 percent of the population accounting for almost half of expenditures).¹² This is the rationale for insurance to spread the risk.¹³ Because financial exposure can be so great, insurance commonly sets a maximum out-of-pocket expenditure beyond which the plan pays the full cost. From the patient’s perspective, once this out-of-pocket threshold is crossed, there is no economic deterrent to seeking more care.

When the need for medical care arises, the consumer becomes a patient and is usually unable to assess appropriately the precise type

and amount of care needed, relying instead on clinicians to make those decisions.¹⁴ Although ideally they reflect the patient's values, such decisions more often are based only on clinical needs as perceived by the physician. When clinicians and health care institutions receive fee-for-service payment, they have incentives to offer all services for which potential medical benefits exceed the additional cost to the patient. For most inpatient care, because the maximum out-of-pocket cost is often reached during the admission, the marginal cost to the patient of additional services may be zero. Thus, as long as a service is expected to offer some benefit, its cost is irrelevant.

To counter this incentive problem, health plans bearing some responsibility for the overall cost of care increasingly ask for information about the medical need for each service provided. This results in extensive and oftentimes problematic communications to assure "prior approval" of coverage before treatment, or retroactive refusals to pay for care already delivered. In practice, prior approval requests are rarely denied, but the process results in substantial provider frustration. Most expensive new interventions are fully (or nearly fully) covered by insurance, so there is no formal consumer-driven market test of their value. It is not surprising that biomedical product developers focus their research on areas with the greatest profit (but not necessarily clinical) potential, but this link between insurance and technology development has not been explored.

Fee-for-service payment also hampers coordination of care. Each provider (for example, physician, hospital, clinic) has economic incentives to offer his or her own "products and services." For various historical reasons, payment rates undervalue time spent with the patient relative to procedures performed. More important, if expert advice avoids the dispensing of unnecessary services, there is no way for the fee-for-service system to share those savings with the expert. Referral patterns reinforce "sequential back-scratching" and routine referral to more expensive care; such behaviors are exacerbated by subspecialization and concerns about liability. Various laws prohibit or constrain gainsharing (colloquially referred to as "anti-kickback"

laws) between providers and institutions or between professionals, even if this may enhance efficiency and/or quality through better coordination of care.

In contrast to fee-for-service, capitation (a yearly payment to cover all services needed by a patient) offers incentives to provide no more than the necessary care, although it frequently does not work this way. The incentives work well if patients and providers are linked together in a long-term relationship and if providers receive payment commensurate with the risks associated with their population of patients. Clinicians then have economic incentives not to overlook a problem in the near term because it might be very costly to them in the long term. Except in highly integrated plans such as the Kaiser-Permanente system, in which the “glue” of an ongoing physician-patient relationship keeps the patient in the system, it is painless for most patients to move from one HMO to another while keeping the same clinicians.¹⁵ This makes it easy, and far more profitable, for the plan to design ways to encourage people likely to be high cost to switch to another plan rather than to address the complicated clinical approaches needed to optimize care. These strategies need affect only a small number of very expensive patients to be highly cost-effective for the plan, and may even enhance quality for those patients if they get to see better-qualified specialists. Such schemes, however, reduce incentives for plans to seek out and effectively manage the high-cost cases, which would likely benefit the most from well-designed care.

The Cost of Operating Payment Systems

Sub-optimal incentives might be acceptable if associated with a payment system that has minimal operating costs. Simple global budgets for hospitals and “no questions asked” fee-for-service reimbursement of clinicians may not have optimal economic incentives, but at least they are administratively inexpensive. The United States, however, has the worst of both worlds. Our payment incentives encourage ever more service delivery. To control costs, payers request pro-

gressively more detailed information about the need for each service, increasing the costs of filing claims, delaying decisions, and/or causing retroactive denials and appeals.

Payers view their administrative functions to reduce expenditures as “value added.” The percentage of premiums paid to providers is referred to as the “loss ratio”; keeping this low (that is, increasing the share of both profit and administrative cost) is assessed positively by financial analysts. The feeling of providers and patients is that “the system” is designed to make the reimbursement process so cumbersome and time intensive that they sometimes simply walk away from demanding payments legitimately due them.

The multiplicity of payers and rules is part of the problem. Each payer attempts to manage its own costs. In the absence of a coordinated effort and/or dominant market player (except Medicare), providers are faced with such a cacophony of rules, requirements, and micro-incentives that most are ignored. Uniform coding of claims data to facilitate electronic submission is only now being done, decades after the credit card industry achieved this goal. The simple alternative of a single payer is politically fraught. Private payers can be expected to resist any public effort to supplant their role, but providers also seem hesitant, fearing that government-mandated rules will be driven by budget and political priorities and will be insufficiently flexible to adapt to new technologies and science.

The Highly Variable Technical Quality of Care

Health care use varies substantially across geographic areas without corresponding differences in outcomes. Some argue that outcomes are actually worse in high-use areas.¹⁶ Although the direct connection between these observations and health care quality is not entirely clear, variations in the use of discretionary services, ranging from rates of cesarean section to days in the intensive care unit shortly before death, reflect supply variations; treatment of non-discretionary conditions, such as repair of hip fractures, however,

bears little relation to supply.¹⁷ There is not much evidence that the patterns, sometimes referred to as “practice style” variations, with higher use offer significant clinical benefit, and the current system provides little incentive for either critical assessment or change of such variations. Partly in response to such findings, in recent years evidence-based guidelines have been promulgated by panels of experts based on findings of well-designed peer-reviewed studies. Adherence by clinicians to such guidelines, however, is highly variable even when there is agreement that the guidelines are relevant.¹⁸ Guidelines are not universally accepted as the best solution. They have been criticized for focusing too heavily on “ideal” cases rather than reflecting real-life practice.¹⁹ There are also cases of special interest groups, such as drug companies, influencing the guideline development process.²⁰

One cause of variable care is the lack of coordination across multiple providers and systems. Information on what was or was not done for a patient is often unavailable. When a patient has multiple problems, it is sometimes difficult to determine which clinician is responsible. It is hard to achieve a good balance between recognizing the unique aspects of a patient’s case and developing more generic measures of quality of care that can be evaluated across many patients.

Assessing Quality of Care from a Patient Perspective

In addition to determining whether clinicians adhere to what is considered “best practice,” one must also assess if it is the care the patient wants and if it is delivered in a manner the patient finds acceptable. We do not think it is enough for an airline to ensure that its planes are well maintained and do not crash; it should also get its passengers to their desired destinations in a timely and courteous fashion.

New measures focusing on patient assessments of care are gaining acceptance, such as the Consumer Assessment of Health Plans Survey (CAHPS); similar measures are available for hospital and other types of care. These weigh aspects of care that only patients can as-

ness, such as getting needed care, receiving care quickly, completing paperwork with ease, and receiving comprehensible information, as well as doctors' communications skills and the courtesy, respect, and helpfulness shown by office staff. Still missing are tools to help patients communicate their preferences for clinical care, including trade-offs among various treatment options, and assess how well these preferences are honored.

Clinicians sometimes disagree among themselves as to what should be done in a specific case. Orthopedic surgeons are less likely to recommend conservative treatment of back problems than neurologists or physical therapists. Apart from the question of economic self-interest, clinicians naturally believe in the efficacy of approaches reflecting their own training, and know less about the skills of others. Even when the existence of alternatives is recognized, explaining options and choices to patients is complex. This is especially true in sensitive areas, such as end-of-life care, involving cultural, educational, and value-based factors that must be considered. Even the words used to describe a situation may be understood differently by various patients. Differing worldviews are part of the problem; a lack of (reimbursed) time prevents clinicians from getting beyond advice targeted to "the average" patient.

Far-from-Optimal Safety

Medical care is not always delivered in a safe manner. Although the Institute of Medicine's estimate of nearly 100,000 hospital deaths a year due to errors is debated by some, the true number is undoubtedly too high.²¹ Medical care involves inherent risk, but in many instances the risk can be reduced through known, inexpensive means. Occasionally these safety problems are attributable to individuals; most, however, reflect failures of system design. Far more deadly than the incompetent surgeon is the hospital that does not enforce hand-washing by its staff. The question is: How do we improve the incentives for organizations to enhance safety?

One area in which the system has particularly flawed incentives is that of malpractice. Various studies show that the vast majority of errors do not result in malpractice claims, that most claims do not result in judgments, and that compensation levels appear random.²² The transactional costs of litigation are substantial, involving attorneys on both sides, expert witnesses, court costs, and the time of and emotional stress on both plaintiffs and defendants.

The tort system underlying a malpractice claim is based on a specific incident involving negligence: without proof of negligence, the claim fails, irrespective of whether there was a bad outcome. “Mistakes” or “errors” are not part of the legal terminology.²³ Not surprisingly, providers have an interest in denying negligence; in addition to the financial implications, the mere accusation threatens the clinician’s and/or institution’s professional image. The great majority of claims are settled without any admission of guilt or public disclosure of evidence. Rather than providing incentives for organizations to identify patterns of bad outcomes leading to process redesign, however, the current system hides data and prevents learning from mistakes.²⁴

Failure to Reward Primary Care Practice

Most clinicians enter their field to care for patients. For some this is accomplished through the ongoing contact of primary care, for others by delivering leading-edge specialty care. Primary care, however, is increasingly unattractive as a profession. There is pressure to raise “throughput”—that is, to see more patients in less time—partly because payment per encounter is low and the fixed costs of practice are substantial. Fee schedules do not adequately reward increased *quantity* of time spent with patients or improved *quality* of time reflected in empathy and understanding. All office visits and practitioners are generally considered by payers to be equivalent. Payers may have “preferred providers” to whom they channel patients, but selection for the panel is often based simply on the willingness to accept

lower fees. Employers typically prefer broad panels of providers but offer little guidance to enrollees about how to choose a clinician. When people change employers, or employers change plans, their “covered” panels of providers may change, breaking long-standing patient-clinician relationships.

Increasing Sense among Clinicians of Deprofessionalization

Many physicians and other clinicians feel as if their “professions” are being taken away. “Professionals” are defined as people in occupations requiring extensive expertise and discretion; professionals are expected to behave according to those standards.²⁵ Although evidence-based practice is almost certainly preferable to practice based on anecdote or outdated training, rigid adherence to guidelines, particularly when monitored and enforced by nonclinicians, transforms their potential utility into a threat.

Whether true or not, the traditional version of professional ethics typically placed compensation in the background; currently it seems to be front and center. Physicians are encouraged to act in a business-like fashion, but when they attempt to do so by becoming owners of their practice environments, they may jeopardize their professional status, as well as occasionally running afoul of legislation intended to prevent certain types of bad economic behavior.

Perception of Technology as the Major Driver of Costs

Most U.S. health economists feel that the long-term growth in health care expenditures is driven by technology.²⁶ Although not all technological innovations are cost-increasing—David Cutler, J. D. Kleinke, and others argue that some innovations have produced markedly better health at lower cost—many innovations hike cost with little net effect on health.²⁷ A key question, however, is whether technological innovation is endogenous—that is, responsive to the incentives implicit in the health care system—or simply the result of the inde-

pendent flow of new scientific exploration. Basic science is plausibly the result of researchers' independently following interesting hypotheses, but it is far less likely that the investments covering research and development (R&D) costs are independent of potential rewards. If R&D is responsive to payment issues, a restructured system could alter that portion of the trend in expenditures that is due to technological change.

Even if health care policy is not explicitly structured to influence the direction of R&D, R&D will be influenced by technological changes on the horizon. The specificity of drugs and devices is increasing, allowing manufacturers to identify better who will benefit from a new product. Manufacturers can then show significant benefits with fewer patients in the trial; but increased specificity limits the scope of the market, therefore raising the price needed to cover R&D costs. Higher prices will lead payers to assess more carefully whether the intervention is substantially better than the alternatives.

What Is Given and What Is Not

One way to view the different approaches to the house problem outlined at the beginning of this chapter is that the "redecorators" accept almost everything as given and think that only minor changes are possible, while the "replacers" accept almost nothing as "given." The first approach is insufficient to address the problems fully; the second is unrealistic. To get beyond these extreme approaches, it is a good idea to outline what really is unalterable.

What Needs to Be Accepted as Given

Suppose one wanted to pursue a strategy of totally revamping the U.S. health care system by "importing" what works in some other country (imagine that by some political miracle the plan was passed into law). The ongoing operation and adjustment over time of the new system would still occur in the context of the American political

system. This is a system in which narrow interests have substantial veto power. The diffusion of power to congressional committees, the power of individual legislators, and the fragmented federal system make coordination and management of a single system difficult to design and operate.²⁸ In the United States, both constitutional interpretation and tradition reserve to the states many powers, especially in the health arena (for instance, professional licensure, the regulation of insurance), all of which challenge the creation of a national system. Although some of the separation of powers issues can be addressed, it may be difficult to do so to the extent that they affect policies outside the health arena.

Likewise, underlying public values are unlikely to change merely because a new health care system is legislated. The notion of “solidarity” (that is, citizens accepting responsibility for one another and agreeing to have everyone covered in the same plan) is common in European discussions but notably absent in the United States. Even Medicare, which comes closest to a universal plan, relies on private contractors and includes an important role for supplemental coverage paid for by individuals or employers. Since the Revolution, Americans have distrusted the ability of government to operate systems and seemingly prefer potentially complicated private sector solutions. The lack of faith in government is self-fulfilling: without respected and well-funded programs, the government has difficulty recruiting highly skilled civil servants. This results in less responsive performance and reinforces those wanting to shift programs to the private sector.

The current players in the health system will not simply disappear because a new financing plan is implemented. The ratio of procedurally oriented specialists to generalists will not change overnight, hospitals will still have too many open heart surgery and MRI units, and bondholders will still own hospital debt. Even if policymakers agree that there is an excess supply of certain health care resources, it is not clear what mechanism would be used to select which hospitals would be closed and which physicians would be excluded from the system.

Health care reform will not change the legal protections of property rights and litigation challenging government “takings.” The legalities aside, appeals to a sense of “fair play” favor not harming those who legally responded to the incentives of the “old system.”

Underlying economic incentives and the behaviors responding to those incentives will not change regardless of the system we implement. Most policy changes are simply intended to alter the details of the incentives to allow them to shape behavior in more desirable ways. Profit maximization will continue to be a principal driver of corporate behavior. For individuals, income maximization is tempered somewhat by both time constraints and other rewards, such as self-esteem. People and organizations generally prefer certainty to risk; many, however, are willing to accept some risk in return for increased rewards. Risk can be predicted and offset by the law of large numbers through insurance, but uncertainty is more difficult to address because the probabilities associated with various outcomes—and sometimes the outcomes themselves—are usually unknown.

What Need Not Be Taken as Given

The current players in the system will clearly be “sitting at the table” as reforms are discussed; it is unreasonable to assume that they can be eliminated from a reform plan. This does not mean, however, that all must be guaranteed the same roles they now play. Insurers, for example, serve many functions in the current system: from underwriting and risk bearing to payment and determination of medical necessity. Some of their skills may actually be underutilized currently because they cannot access the necessary data. A restructured system should consider how best to utilize the expertise and comparative advantage of all the players. We should also not assume that employers must be the primary source of specific forms of health insurance coverage, but rather consider other roles that better fit their special connections to workers.

Underlying social and political values may change at a glacial pace,

if at all. New ideological labels are more likely to reflect new “framing” of positions than actual changes to the health care system’s operations. That said, a restructured system should draw upon what is most beneficial from private and public sector solutions, market and collective decisions, at both local and federal levels. Changes in roles and responsibilities may be both necessary and freeing.