

MAYO CLINIC SCOTTSDALE

The following will be held: "EMG in Clinical Practice" (Scottsdale, Ariz., Jan. 21-23); "Mayo Interactive Surgical Symposium in General Surgery" (Scottsdale, Ariz., Feb. 24-26); "Clinical Reviews 1994" (Phoenix, Ariz., March 10 and 11); and "3rd Annual Urogynecology and Disorders of the Female Pelvic Floor" (Phoenix, Ariz., March 24-26).

Contact Tamara Zelinski, MCS, 13400 E. Shea Blvd., Scottsdale, AZ 85259; or call (602) 301-7447.

COMPLICATIONS OF DIABETES: DIAGNOSIS AND TREATMENT

The course will be offered in Burlington, Mass., on Jan. 12.

Contact Middlesex District Medical Society, Society Headquarters, 26 Brighton St., Suite 207, Belmont, MA 02178; or call (617) 484-8363.

UNIVERSITY OF UTAH

The following courses will be offered in Salt Lake City, unless otherwise indicated: "Lead Abatement Training — Inspector" (Jan. 12-14); "Fundamentals of Industrial Hygiene" (Jan. 17-21); "Air Sampling for Toxic Substances" (Feb. 1-4); "Current Concepts in Occupational Medicine" (Park City, Utah, Feb. 9-11); and "Introduction to Industrial Toxicology" (Feb. 14-18).

Contact Administrative Secretary, Rocky Mountain Ctr. for Occupational and Environmental Health, UU, Bldg. 512, Salt Lake City, UT 84112; or call (801) 581-5710.

ADVANCES IN NEUROLOGY

The course will be offered in Acapulco, Mexico, Jan. 15-22.

Contact Millie F. Walden, 3425 S.W. 2nd Ave., #154, Gainesville, FL 32607; or call (904) 373-9765.

NEW YORK ACADEMY OF SCIENCES

The following conferences will be held: "Inhibition of Matrix Metalloproteinases: Therapeutic Potential" (Tampa, Fla., Jan. 19-22); "Coronary Artery Spasm" (New York, Feb. 22-25); "Brain Corticosteroid Receptors: Studies on Mechanism, Function and Neurotoxicity of Corticosteroid Action" (Arlington, Va., March 2-5); and "T-Cell Receptor Use in Human Autoimmune Diseases" (San Diego, Calif., April 18-21).

Contact NYAS, Conf. Dept., 2 E. 63rd St., New York, NY 10021; or call (212) 838-0230.

WHAT'S NEW IN INTERNAL MEDICINE?

The course will be offered in Stowe, Vt., Jan. 24-28.

Contact American Coll. of Physicians, Independence Mall West, 6th St. at Race, Philadelphia, PA 19106-1572; or call (800) 523-1546, ext. 2429 (natl.) or (215) 351-2429 (Pa.).

SPECIAL REPORTS

THE FRAMEWORK OF HEALTH CARE REFORM

PRESIDENT Clinton's Health Security plan is a distinctively American synthesis. Like universal health insurance in other industrialized countries, it covers a comprehensive set of benefits for all citizens and makes health coverage a right of citizenship. But unlike most systems abroad, it offers consumers the opportunity to choose among private health plans.

Like programs abroad, the Health Security plan establishes national limits on the growth of health costs for covered benefits. It places a distinctive emphasis,

CLEVELAND CLINIC FOUNDATION

The following courses will be offered in Cleveland, unless otherwise indicated: "Dental Hygiene" (Jan. 19); "Ophthalmology" (Jan. 21 and 22); "Urologic Surgery" (Jan. 24-28); "Orthopaedic Nursing" (Feb. 24 and 25); "Colorectal Disease in 1994" (Ft. Lauderdale, Fla., Feb. 24-26); "Neuropathology Board Review" (Feb. 26); and "Enterostomal Therapy" (Ft. Lauderdale, Fla., Feb. 26).

Contact CCF, Dept. of CME, TT-31, 9500 Euclid Ave., Cleveland, OH 44195; or call (800) 762-8173 (natl.) or (216) 445-6030 (Ohio).

AMERICAN DIABETES ASSOCIATION

The "31st Annual Colorado Diabetes/Endocrine Institute" will be held in Aspen-Snowmass, Colo., Jan. 22-27.

Contact ADA, Colorado Affiliate, 2450 S. Downing, Denver, CO 80210; or call (303) 778-7556.

NATIONAL KIDNEY FOUNDATION

The "3rd Annual Spring Clinical Nephrology Meetings" will be held in Chicago, April 7-10.

Contact NKF, 30 E. 33rd St., New York, NY 10016; or call (800) 622-9010 (natl.) or (212) 889-2210 (N.Y.).

ELECTROCARDIOGRAPHY FOR PHYSICIANS

The "Advanced Workshops" will be held in Clearwater Beach, Fla., Jan. 23-26, June 26-29, and Nov. 2-5.

Contact Rogers Heart Fdn., 1994 CME, St. Anthony's Hosp., P.O. Box 12588, St. Petersburg, FL 33733; or call (813) 894-0790.

AMERICAN INSTITUTE OF POSTGRADUATE EDUCATION

The following courses will be offered in Maui, Hawaii, unless otherwise indicated: "Update: Controversies in Emergency and Primary Care" (Kona, Hawaii, Jan. 22-29); "17th Annual: Neurology for Non-Neurologists" (San Diego, Calif., Feb. 3-5); "Pediatric Emergencies" (Snowbird, Utah, Feb. 5-12); "Cardiac Emergencies" (Feb. 25-March 5); and "Sports Medicine" (March 5-12).

Contact Edith S. Bookstein, AIPE, P.O. Box 2586, La Jolla, CA 92038; or call (619) 454-3212.

SCRIPPS CLINIC AND RESEARCH FOUNDATION

The following courses will be offered in La Jolla, Calif.: "Cutaneous Malignancies: 1994 Skin Cancer Update" (Jan. 21-23); "New Advances in Inflammatory Bowel Disease" (Feb. 5); "Clinical Hematology and Oncology: 1994" (Feb. 21-23); and "1994 Sleep Medicine Update" (Feb. 26).

Contact SCRPF, Dept. of Academic Affairs, 403C, 10666 N. Torrey Pines Rd., La Jolla, CA 92037; or call (619) 554-8556.

however, on helping consumers obtain value for money by requiring health plans to compete for enrollment on the basis of both price and service. The Health Security plan does not only seek to restrain costs through competition. What is equally important, it also creates a new system of monitoring and improving quality to hold health plans and providers accountable for access to services, the appropriateness and effectiveness of treatment, and consumer satisfaction.

When other major industrialized countries made health insurance universal, they built on institutions that already existed. The Health Security plan follows this pattern. Although it breaks with many entrenched practices in the private insurance market, it builds

on the integrated health plans, new methods of quality improvement, and other reforms that have been developing in both the private and public sectors in America.

The plan's federal structure also reflects American experience. Although the framework of coverage, benefits, consumer protection, and financing is national, the states have the opportunity to play a major part in carrying out reform and adapting it to their own circumstances. A state that prefers to adopt a single-payer system may do so as long as it complies with national guarantees regarding coverage, benefits, quality of care, consumer rights, and ceilings on the rate of growth in health premiums.

The program's balanced use of competitive and regulatory mechanisms and the flexibility it affords to states defy conventional pigeonholes. Ideologists and purists will be disappointed. Yet the plan represents no weak middle ground. It is a bold program of reform, grounded in the experience that lesser measures to control costs and expand access have not worked.

TEN KEY JUDGMENTS

The Health Security plan reflects not only the accumulated experience and evidence of recent decades, but also a series of judgments about the kind of reform America needs.

Judgment 1. Cost containment and universal coverage are achievable. The cost of health care is not the result of forces beyond our control. Other advanced countries cover all their people at far lower and more stable costs and with higher levels of public approval (not to mention longer life expectancy). In some states and communities in the United States, from Hawaii to Rochester, New York, coverage is nearly universal and costs are below the national average.

The difference lies in institutions. Much research has demonstrated the excesses in the prevailing system: we train too many specialists, overbuild high-cost facilities, perform more tests and procedures than are good for our health, and maintain billing and administrative arrangements of numbing complexity. Nowhere else in the world do small employers buy health insurance at such high administrative costs — 40 cents on the premium dollar for the smallest firms.

At 14 percent of the gross domestic product and rising, the American health care system consumes enough resources to provide health security to every citizen. As in other countries, the same financing discipline needed to make access affordable can keep health costs in line with the rest of the economy.

Judgment 2. Reform must be comprehensive. Any program that pursues broader coverage to the exclusion of cost containment will rightly be judged irresponsible. Such a program could never be sustained if it could ever be passed.

Similarly, any program that pursues cost contain-

ment to the exclusion of broader coverage will rightly be judged inequitable. New burdens would fall on the most vulnerable, as providers cut back on uncompensated care.

Comprehensive reform means controlling private as well as public costs. If we were only to control the cost of government programs, providers would shift those costs to private payers (as they do today when rates of Medicare and Medicaid payment are held down).

Comprehensive reform means addressing the sources of the system's excess. It means creating larger purchasing pools to spread risks and give buyers more clout, shifting government support for medical education to promote training in primary care, and setting new standards for claims forms, benefit packages, and payment to simplify the system's complexity and cut administrative costs.

Universal coverage is not optional; there is no way to ensure security even for the middle class without filling the gaps in coverage. There is no way to carry out welfare reform if taking a low-wage job means losing health benefits. And there is no way to make cost containment an ethical or even morally acceptable policy or, for that matter, a practical success without guaranteeing coverage for all.

Minimalist alternatives will not be sufficient. Some people would prefer just to subsidize coverage for the uninsured while leaving current private insurance in place. But the existing insurance system is at the root of the problem. Under current rules, insurers compete to avoid risks, not to control costs or to improve care. Without reform, costs will continue to rise sharply and more people will lose coverage. Furthermore, if subsidies were available to those without employer-provided coverage, fewer employers would provide it, and the costs to the Treasury would skyrocket.

Although insurance market reform is necessary, it, too, will not control costs or achieve universal coverage. While curbing some of the most egregious practices of the insurance industry, such as exclusions of preexisting conditions, insurance market reform — if adopted alone — would only spread costs more equitably. It would fail to address the deeper problems that make health care more costly in the United States than anywhere else.

Providing coverage only for catastrophic illness is another minimalist option that will provide no real remedy. Attempts by nonprofit foundations and some states to promote minimal coverage for the uninsured have flopped; the public does not buy the policies. Bare-bones coverage also leaves the basic problems of the system intact. It does not correct the overemphasis on high-cost procedures, overproduction of specialists, or high administrative costs. Catastrophic-illness insurance (that is, coverage that kicks in after a deductible of \$1,000 or more) tends to discourage the use of preventive and primary care, but once the beneficiary's expenses exceed the deductible, it puts little check on the most costly services.

Judgment 3. A pure free-market solution will not work in health care. Some advocates of the free market believe that the public is overinsured. To discourage the use of health care resources and bring down costs, they want national policy, particularly tax policy, to encourage people to buy insurance policies with higher deductibles and copayments.

Their premise is that the key to cost control lies in individual choice and cost-consciousness at the time consumers seek medical care. However, when ill and in need of care, most patients cannot readily shop around comparing prices. They generally do not feel they know enough even to ask the right questions. When they first seek medical care, people usually are uncertain about what their treatment will ultimately involve, much less cost. And once they are in the middle of treatment, changing providers is often not feasible. Particularly when patients are hospitalized, decisions about treatment are in the hands of doctors and other professionals. For most patients in the midst of illness, therefore, price-conscious purchasing is literally impossible.

In health care — unlike most other industries — the providers, not the consumers, shape the demand for the most costly services. This reversal of the normal market relation has critical implications for any strategy to control costs. The volume of services and hence total costs depend on the number, characteristics, and incentives of the suppliers. Under the current system, the greater the supply of hospitals and specialists, the higher the costs. Recognition of that fact must underlie the strategic focus of reform. To create cost-consciousness, reform needs primarily to encourage change in the decision-making environment of the organizations that deliver services and of the professionals who provide it.

To be sure, a system that required patients to bear a large share of the costs of each service would reduce costs, but it would do so by discouraging necessary as well as unnecessary care. Moreover, as Medicare shows, attempting to impose high deductibles and copayments on the middle class is likely to be fruitless. The majority of Americans would buy additional coverage to reduce the cost-sharing, as the elderly do today; the use of services would then increase, raising the costs of the basic benefit package. Today, some elderly people even buy two or three duplicate policies to cover cost-sharing. From an economic standpoint, this is a poor choice. But because they feel vulnerable in the face of staggering medical bills and an incomprehensible insurance system, many people are not willing to risk any exposure to health care costs.

This sense of vulnerability limits the appeal of free-market remedies. The public understands the need for cost containment. But people who feel vulnerable and insecure will distrust any cost-control program that seems to put them at risk. The free-market approach, ironically, fails its own test: It doesn't sell.

Judgment 4. A purely governmental solution to health care costs and coverage will not work in the United States. Encouraged by the example of Canada, many Americans look to a single-payer system as the most complete solution to the health care crisis.

A single-payer system on a national scale, however, would require a tax increase of unprecedented size. To transfer all private health care coverage to the federal budget would be daunting. The unbridled growth of Medicare alone poses a threat today to the federal government's solvency.

A Canadian-style system in the United States might not produce Canadian-style costs. Combining Canada's fee-for-service insurance with America's excess hospital capacity, overinvestment in technology, and oversupply of specialists might well generate costs at America's level, not Canada's.

Excess capacity in the U.S. health system is the fundamental problem that confronts a Canadian-style alternative. Squeezing out excess capacity is not an easy thing for government to do; it is probably harder to shut a hospital than a military base. In recent decades, states have even found it difficult to close psychiatric hospitals that were virtually empty. In contrast, a competitive system creates incentives for private organizations to do what government itself cannot easily do: consolidate facilities, increase the employment of primary-care practitioners relative to specialists, and gear payment to performance.

A competitive system also provides for more decentralized organization. Each health plan has its own planners and managers. If they make mistakes, their organization may lose ground, but other plans may discover better solutions. Like any market, a competitive system of health plans is more capable of self-correction.

Judgment 5. A reconstructed market in health plans — backed up by nationally budgeted limits on the growth of premiums — can control costs. Between the extremes of a purely free market and a wholly government-run health care system lies another alternative: a reconstructed market with new rules, incentives, and limits. This is the approach of the Health Security plan.

This approach differs from the free-market remedy in critical ways. It does not shift back onto consumers a greater share of costs in the hope they will seek less care; it does not count on consumers to make economizing choices when they are ill. Rather, it guarantees consumers broad coverage. It then gives them the opportunity to reap the savings if they choose a health plan that provides that coverage at lower cost, and it asks them to pay the difference if they prefer a more expensive plan. In other words, the Health Security plan first seeks to create a foundation of security and then introduces cost-consciousness — not when people are ill, but at the time they select a health plan.

The approach rests on the conviction that integrated health plans can do better than the existing, fragmented system. Such plans now deliver high-quality services more economically than traditional indemnity insurance. Yet they do so in a system that often does not give consumers a choice or reward the more efficient providers of care. Many employers contribute more toward health insurance plans that cost more, and the majority of employees have little or no choice among competing health plans. If the financing system expands choice, rewards efficiency, and spurs competition, plans that provide better value will grow.

Should the plans fail to keep premiums down through the spur of competition, however, the Health Security plan has a backup system of caps on the growth of health plan premiums. The caps kick in when the average growth in premiums in a region threatens to exceed a national index rate.

There is both direct and indirect evidence that competition can control costs and that if competition fails, budgets set prospectively can check increases. Some of the direct evidence comes from research on health maintenance organizations (HMOs) and other plans that provide comprehensive coverage for a fixed amount for each participant. These organizations illustrate the potential of both competition and budget constraints. On the one hand, the plans now compete effectively on the basis of price and service. On the other, they already provide broad coverage under a "hard" budget constraint (determined by their enrollment and per capita rates).

Competition, capped increases in spending, and a third element of reform — accountability for quality — go together. Integrated health plans fit readily into a system of budgeted growth in premiums because they already operate within a budget. Moreover, the very nature of comprehensive payment for services focuses accountability for the total cost and quality of service on a single organization. In contrast, the prevailing fee-for-service system diffuses responsibility for cost and quality among insurers and providers, often without any coordination among them.

The reformed financing system changes the outlook of health care managers. Under conventional insurance, the managers look at a hospital as a revenue center. When they are paid per capita for comprehensive services to an enrolled population, they look at a hospital as a cost center. The caps on premium growth reinforce the shift in attitude. Instead of bending their efforts to milk the reimbursement system, managers must discover how to cut their costs and raise productivity. If they cut costs at the expense of access (leading to longer waits for care), patients can sign up for another plan that is more efficient and better able to serve them. Similarly, a plan that cuts costs at the expense of quality would risk public exposure through the system that monitors quality and consumer satis-

faction. Such a plan would also be likely to alienate its own physicians, nurses, and other providers.

Compared with conventional insurers, integrated health plans such as HMOs and provider networks are better organized to improve quality because they are responsible for providing care as well as for payment. The new quality system will push them in that direction even more. Under reform, health *insurers* will probably become — or be displaced by — health *plans* that have broader responsibilities than processing claims. Providers themselves are well positioned to create such plans.

Although integrated plans are likely to expand under the new system, the Health Security program also embraces more conventional fee-for-service options. Perhaps the most common misunderstanding is that the program aims to force people to enroll in HMOs. In fact, it attempts to keep fee-for-service plans viable. Furthermore, all prepaid plans will have to offer a point-of-service option.

Fee-for-service plans will come in two varieties: those that have contracts with networks of providers and those that do not. Fee-for-service networks will be able to respond to the competitive challenge of HMOs by working with their physicians to control costs. The fee-for-service plans without networks (conventional insurance plans that pay any willing provider) will use a rate schedule negotiated by the alliances and physicians to keep their premiums in line. Alternatively, the states may choose to collapse all such insurance plans into a single prospectively budgeted plan for all willing providers and run it like a German sickness fund — that is, adjusting rates throughout the year to keep total costs within budgeted limits. Whichever method is used, fee-for-service care is likely to be more affordable than in the present market.

The higher cost-sharing allowed for fee-for-service plans, particularly the 20 percent coinsurance for hospital care, is also likely to minimize any advantage that HMOs have in premiums (though, to be sure, it will add to out-of-pocket costs for fee-for-service enrollees). Some other aspects of reform, notably risk-adjusted payments to plans, will tend to reduce disadvantages that fee-for-service insurance now faces in the marketplace, because they would take into account any tendency of older and chronically ill people to prefer fee-for-service care. Thus, the Health Security Act may actually preserve fee-for-service plans at a time when they are threatened with extinction.

Some advocates of a competitive model are opposed to negotiated fee schedules and budgeted caps on average premium increases. They object that such regulatory controls are not only unnecessary but also damaging to the competitive process.

However, relying on competition without any caps on premium increases would pose unacceptable risks. First, broad areas of the country do not yet have vigorously competing health plans; some may never have

competition because of the low density of their populations. The caps will be especially vital in those areas to limit cost increases. The caps also serve as a check on the use of oligopolistic or monopolistic power by plans and providers in other regions.

Second, the caps provide discipline to the system. When making decisions that affect their costs, plan administrators and providers will have a clearer idea of how fast they can expect revenues to grow in the future. Just as high rates of inflation in the economy at large create expectations that help to generate more inflation, so rapidly rising health revenues have generated expansionary pressures in health care. The caps act as a damper.

Third, disputes among experts about the amount of potential savings resulting from competition make it difficult to rely entirely on competition to control costs. The Congressional Budget Office, for example, acknowledges that if certain specific criteria are met, managed competition may well reduce costs, but it professes to be unable to predict the magnitude of savings, for lack of definitive evidence. The Health Security program's dual reliance on competition and caps responds to the reality that skeptics need more assurance about cost control than competition alone can provide.

Judgment 6. A new framework for purchasing and budgeting health coverage is critical to reducing the rate of growth in costs. The pivots of reform are new organizations for purchasing coverage and capping growth in costs — the regional health alliances. Without them, or if they are only voluntary, insurers will continue to be able to cherry-pick the healthy and shun the sick. And without alliances, the choice of a health plan — and increasingly of one's doctors — will remain with employers, not shift to individual consumers.

Known in other proposals as "health insurance purchasing cooperatives," the alliances will perform several functions. First, they will pool risks among employee groups and individuals and provide them the benefit of economies of scale and a wider array of options. No longer will some people pay more for the same coverage simply by virtue of working for a small firm or because they are divorced or widowed and must buy coverage individually.

Second, the alliances will empower the purchasers — employers and consumers — by constituting a single purchasing organization to negotiate with plans and providers about service and price. The purchasers of health care have historically had little influence; the alliances are designed to represent their interests and give them a critical role in decisions about the flow of dollars. One way to control costs is to give more control to the people who pay. The alliances provide consumers an independent voice and venue, which they have never had.

Third, the alliances help to prevent insurance plans from continuing to enroll the healthy and avoid the

sick. If plans were able to sign up individuals directly, they would seek the most favorable health risks. Thus, it is vital that the alliances conduct the annual open enrollment independently of any plan, provide independent information to consumers about their alternatives, and adjust payments to plans according to risk to minimize any advantage the plans might otherwise enjoy from skimming off the healthy or any disadvantage from enrolling high-cost subscribers. Competition will not succeed in bringing costs under control if plans can cut their costs by screening out sick people rather than by managing services efficiently.

Fourth, the alliances are as critical to the success of caps as they are to the success of competition. We cannot set any effective limits on the growth of health costs today partly because we lack the infrastructure to do it; the alliances provide the missing element. They make it possible to establish and enforce a regional cap on the growth of expenditures for the guaranteed benefit package without setting specific prices paid to providers. The more broadly based the alliances, the better they will be able to rein in total costs. By including all firms with up to 5000 employees, the Health Security plan creates that broad population base. However, if firms with as few as 100 employees, for example, were allowed to self-insure, the alliances would be much weaker, and the number of firms to be monitored separately would be so large that caps would probably be unenforceable.

Finally, the alliances break the link between employment and health coverage. Because individual consumers rather than their employers will choose among health plans, changes in employment will no longer disrupt coverage. The old model of employer-provided insurance fit a society in which families depended on one earner with one stable, long-term job. In a highly mobile economy, with many two-earner families, employer-provided insurance no longer works well; coverage through alliances makes more sense.

Judgment 7. The federal government must guarantee a comprehensive benefit package. Any reform that seeks to ensure security cannot ask Americans to step down to a lower level of coverage than they now have. Clearly, benefits must be weighed against costs, but a competitive system will in fact work better if the benefit package is relatively uniform and comprehensive.

A comprehensive range of benefits, with limited variation in cost-sharing, is vital to having plans compete on price. The endless variations in benefits, differences in definitions of covered services, and complex cost-sharing provisions typical of health insurance today make it virtually impossible for consumers to compare policies.

Part of the issue is psychological. If consumers worry that a less expensive plan is cheaper only because of hidden exclusions, they will not feel safe choosing a lower-cost alternative. This is the current situation.

Moreover, when insurers are free to design coverage, they tend to offer policies that appeal to the healthy rather than the sick. The result is to make scarcer the kind of coverage that many of the sick need.

A system that provided only minimal benefits would result in the extensive purchase of supplementary coverage. Today, 9 out of 10 Medicare beneficiaries either have Medigap insurance or qualify for supplemental coverage under Medicaid. In both cases, the supplementary coverage reduces patient cost-sharing and increases the use of resources under Medicare. As a result, costs are effectively unchecked. Similarly, if the new federal program for the under-65 population provided for higher cost-sharing and lower benefit levels, the great majority of people would purchase extra coverage, while the poor would continue to be covered by Medicaid or receive additional cost-sharing subsidies. Thus, limiting benefits would not actually reduce costs, except for the small minority of beneficiaries who would have no extra coverage. In the United States, supplementary coverage is the rock on which the ship of minimalist reform almost unavoidably crashes.

It is not extravagance, therefore, to favor a comprehensive benefit package. On the contrary, we are more likely to restrain total costs by making a single organization fully accountable for comprehensive coverage than by encouraging coverage to be split between a basic package and extensive supplementation.

Judgment 8. A reformed system must rely primarily on premium contributions by employers and employees. Most money for health insurance today comes from premium payments by employers and employees. The Health Security plan will extend this system and make health coverage universal.

Maintaining a premium-financed system not only preserves continuity with present financing arrangements but also makes it unnecessary to introduce major new taxes. It avoids transferring the full risk of health care costs to the public treasury. It minimizes the number of people who will see their costs increase. And by building in discounts for low-wage small businesses and people with low incomes, such a system can limit costs according to employers' and employees' ability to pay.

Employer and employee contributions for health coverage are fundamentally different from a tax paid into a general or earmarked fund in the public treasury. In the case of a tax, there is no direct, individual service or benefit received in return. In the case of health coverage, the contributions purchase an insurance policy. Moreover, for the many who receive subsidies and discounts, the value of the policy far exceeds the premium paid.

An employer mandate for health coverage is comparable to auto insurance. If you want to drive a car, you must pay for auto insurance. Likewise, after health care reform, if you want to operate a business you will have to contribute to your employees' health insur-

ance. In both cases, the requirement to buy insurance prevents free riders from exposing others to higher costs and unacceptable risks.

Judgment 9. A reformed system with price competition and caps on premium increases requires equally strong measures to improve the quality of care. Besides measures to control costs, the Health Security plan calls for a variety of initiatives to improve the care Americans receive. These include increased support for primary and preventive care, new funds for research on the outcomes of alternative treatments, and technical assistance to plans and providers in learning how to correct the root causes of poor care.

Rather than simply assume that these measures will be effective, the Health Security plan establishes a new system to monitor access to services, the appropriateness of care, consumer satisfaction, and the outcomes of treatment. The resulting data will be combined in an annual public report on how well health plans and providers are performing with respect to key criteria. The reports will be available to consumers when they choose plans and will provide feedback to health care providers, helping them do a better job.

Today, in contrast, consumers and providers have little objective information about the quality of health care. As a result, many people mistakenly equate more treatment and more expensive treatment with better treatment. The new emphasis on indicators of performance will provide a more accurate basis for assessing quality and for making any needed mid-course corrections in health reform.

Some critics worry that reform will compromise the quality of care by stimulating the growth of cost-conscious, integrated health plans, such as HMOs. However, research does not show that integrated health plans achieve their savings by compromising the quality of care. The potential for simultaneously reducing costs and improving quality is enormous precisely because the conventional insurance system has for decades promoted excessive investment in high-cost facilities and wasteful patterns of practice.

The Health Security plan aims to change the incentives from those that encourage doing more to those that encourage doing better. If American industry has learned one lesson in recent years, it is that improved quality is consistent with reduced costs. Poor quality is costly; it is less expensive to do things right the first time than to do them over. And it is better to encourage employees to cooperate in improving productivity than to focus on identifying and punishing the few bad apples. Health care reform requires the same orientation, engaging practitioners in a cooperative effort to improve overall patterns of care rather than imposing case-by-case, punitive regulation.

Judgment 10. States should have primary responsibility for managing reform within a federal framework. Many states have taken the initiative in health reform, but legal and political barriers beyond

their control have prevented them from moving quickly or fully to solve the problems of cost and access. The Employee Retirement Income Security Act (ERISA) and federal laws governing Medicare, Medicaid, and other programs limit what the states can do. Moreover, individual states cannot readily take the initiative in financing. If a state acts alone, employers may move out and sick people unable to obtain care elsewhere may move in.

As state health policy leaders recognize, federal action is imperative in defining the framework of reform — particularly financing, coverage, and benefits. Many Americans live in one state and work in another; millions move from one state to another each year. If Americans are to enjoy genuine security, they must have national standards and guarantees.

But while the framework of reform must be national, much of the operational responsibility can and must be decentralized. Because integrated health plans are now almost entirely regional (and probably should remain so), the purchase of coverage and organization of services are best kept at a regional level. To be sure, the federal government must have sufficient authority to ensure that standards are met if states fail to pass their own legislation and set up alliances. But the states should be vested with primary responsibility to encourage them to adapt the national framework to their own conditions and make them partners, rather than antagonists, in the enterprise of reform.

A FRAMEWORK FOR CHANGE

For 75 years, health care reform has been one of the great unfinished items of business on the American agenda. If Americans are finally to discover the common ground necessary for change, we need a framework that provides security and choice to consumers

and that invites variety and invention in the marketplace and among the states. The Health Security plan provides that framework.

The plan also encompasses other initiatives besides those mentioned here. It introduces coverage for prescription drugs under Medicare and a new program of home- and community-based long-term care for the disabled and the elderly. It merges the acute care Medicaid program with the health alliances, eliminating the existing two-tier system of payment. It provides for a shift in medical training toward primary care and a new and more equitable basis of funding for academic health centers. It alters the relationship between health care providers and insurers through changes in antitrust law. It expands support for community health centers and other providers in underserved areas.

No administration has ever before presented a program of health care reform as comprehensive and as detailed. But while the details are far-ranging and complex, the vision behind them is consistent. Americans value health care; we spend more money on it than any other country, and after reform we will continue to spend more. But we must be able to get better value for what we spend — secure and comprehensive coverage for all Americans; the opportunity for consumers to make informed choices about the care that best suits their needs; a system that not only preserves good care but continually strives to improve it; and broad acceptance of the responsibility for sharing in the cost and for keeping that cost in line with our economy. As the national journey of reform unfolds, those central objectives must never be lost sight of along the way.

Former Health Care Policy Advisor
to the White House and Professor
of Sociology, Princeton University

PAUL STARR, PH.D.

CHANGES IN THE DELIVERY OF CARE UNDER COMPREHENSIVE HEALTH CARE REFORM

PHYSICIANS occupy a pivotal position in the health care system. Economist Victor Fuchs has called them the captain of the ship, responsible for the large majority of decisions that direct the treatment of patients and determine what happens to them.¹ Physicians also understand the health care system as no one else can. They know when the system works and when it fails.

The critical test of the Health Security Act will lie in the day-to-day practice of medicine. How will it work for patients? How will it work for doctors? Will reform through the Health Security Act foster better access, more continuity, and higher-quality care? Will physi-

cians be able to care for patients in a way that is professionally rewarding? The answers to these questions are key to the success or failure of the reform effort — and to the quality of care we ultimately deliver to patients.

STRUCTURAL CHANGES IN THE DELIVERY OF CARE

Provisions in the Health Security Act that guarantee security and a comprehensive package of benefits will simplify physicians' daily practice and allow them to provide better clinical care. No longer will physicians have to worry about patients' forgoing health care because they are uninsured or underinsured. No longer will doctors have to ferret out details of a patient's insurance policy to see whether a needed service is covered. Preventive services such as mammography, poorly covered under many plans today, will be