

Working Paper No. 95-1

**America's Health System Reform Effort and the
Emerging Paradigm in Health System Reforms**

by

Dov Chernichovsky, Ph.D. (Economics)*

Contents

Abstract

- I. Introduction
- II. The Emerging Paradigm
- III. The Clinton Proposal and the Emerging Paradigm
- IV. A Modified Clinton Proposal under the Emerging Paradigm
- V. Conclusion

Notes

Abstract

The effort to reform the American health system needs to be resumed sooner or later in order to achieve two principal objectives. The first is to reduce the unparalleled growth in America's medical expenditure and thereby improve the nation's competitive position in international commerce and its general economic well-being. The second is to provide higher levels of access to medical care for all Americans and thereby improve national health levels. Such renewed effort can readily build on the now mute Clinton Program by aligning its framework with the financing and administrative principles of the health care system Paradigm which is emerging in most other nations comprising the Organization for Economic Cooperation and Development (OECD). Although overall the Clinton Program was consistent with the Paradigm's objectives, the Program failed conceptually by not separating the different systemic functions and institutions according to their different market and administration principles as stipulated by the Paradigm. Those are the institutions and principles which govern (a) health care financing, (b) organization and management of care for consumers, and (c) care provision. This conceptual failure contributed to the proposal's political difficulties and, if implemented, would have left the average American with less choice than is available to his or her counterpart in other nations under the Paradigm. The alignment of the Clinton Program with the Paradigm would change the principles of financing of care, defining the role of the proposed regional Health Alliance as just a quasi-public financing entity. At the same time, unlike the Program proposal, this alignment would leave intact other competitive principles and institutions making up the American medical care scene. Those are the very principles and institutions that have been admired and adopted by most health care reforms undertaken within Paradigm principles in other nations.

Key words: Health system, Reform, Clinton program, Emerging paradigm

I. Introduction

The proposed Clinton Program designed to reform the health care system in United States of America, is now mute.¹ However, relevant international experience and perspectives clearly suggest that the system remains in need of reform; in particular, it remains rather essential to promote improved access to medical care and reduce the rate of growth in its cost.

American levels of access to care are low and costs of care are high compared to most other nations which comprise the Organization for Economic Cooperation and Development (OECD), nations which share America's heritage, political ideas, and economic principles.² This state of affairs contributes to weakening the nation's political and economic status, resulting in a real cost to all its citizens. Americans, as a whole, get relatively less value than citizens of other developed countries for the nation's high outlays on health care, a fact which undercuts America's standing as a model for economic efficiency and so-called 'social justice'. Moreover, America's unparalleled growth in, and level of, medical care costs contribute to the nation's declining international economic competitive position. These are realities that must be faced and the costs borne by all Americans regardless of each person's level of access to care and conviction regarding the nature of America's health system.

Consequently, as in most other OECD nations, renewed reform efforts will eventually have to be undertaken in America, ideology and political doctrine notwithstanding. And, in the end, such efforts may not deviate substantially in their objectives and underlying system organization and management principles from the common principles that have been emerging from the collective experience of other industrialized democracies since the beginning of the eighties.^{3,4} Hence, there is a need to carry out a technocratic rather than an ideological examination of America's most recent reform effort, the Clinton Program, and any subsequent proposals which may follow.

Perhaps one of the major weaknesses of the Clinton Program was its conceptual deviation from, or possibly outright inconsistency with, what are becoming accepted principles that serve the rather universal health system objectives which the Clinton administration tried to achieve. This deviation introduced a substantial measure of conceptual and institutional ambiguity that most likely compounded the political problems of the proposed Program.

The objectives of this paper are two. The first is to contrast the proposed Clinton Program with the objectives and principles of what appears to be the 'Emerging Paradigm' of health system reforms in most OECD nations and even in

the Russia of today.⁵ The second is to suggest what the proposal should have looked like in view of this Paradigm, possibly as a guide to future effort.

II. The Emerging Paradigm

Despite the great variety of health care systems in industrialized or developed (mainly OECD) economies, the objectives and principles that have guided reform of these systems during the last two decades are quite similar. Indeed, a universal outline or paradigm for health system financing, organization, and macro-management is emerging.⁶ This paradigm cuts across ideological (private versus public) lines, and across conceptual (market versus centrally planned) frameworks, by combining the best elements of both. That is, it addresses technocratic, rather than ideological, concerns and promotes mainly cost control, equity and social efficiency, along with consumer satisfaction.

In the emerging paradigm, three key systemic functions are identified and distinguished: (a) the financing of care; (b) the organization and management of care consumption (OMCC) ; and (c) the provision of care. Reforms in line with this paradigm attempt to combine the advantages of the public system -- universal access to a basic package of care and effective control of spending -- with the advantages of decentralized, mainly private systems -- consumer satisfaction and efficiency in the production of care.

Consequently, performance of the first function, i.e., financing of care, is founded upon principles of public finance, although this does not necessarily imply funding from general government revenues only. Financing can be grounded on income-based earmarked taxes, or some similar system (income- rather than risk-based), mandatory contributions to non-governmental, and even private, agencies. Likewise, the performance of the third function, i.e., provision of care, is based upon decentralized management and elements of competition, without necessarily implying privatization or commercialization of care.

As regards the second, OMCC, function, depending upon demographic, epidemiological, geographic, administrative, and even cultural circumstances, this function can be based on public-centralized, competitive-decentralized principles, or a combination thereof. Consequently, this function can be carried out by public administrations or non-governmental for-, or not-for-profit institutions.

The OMCC function is probably the most distinctive element in the emerging

paradigm. This function in many ways involves group representation of consumers regarding the nature of the care that consumers receive under their public finance entitlement. This representation is both *vis-à-vis* the government on the one hand and the providers on the other. It aims to make the nature of care provided under public entitlement more pluralistic than when managed by a public administration, but, at the same time, less individualistic than when managed mainly by providers who can manipulate uninformed clients (even under the auspices of public finance/contracts).⁷

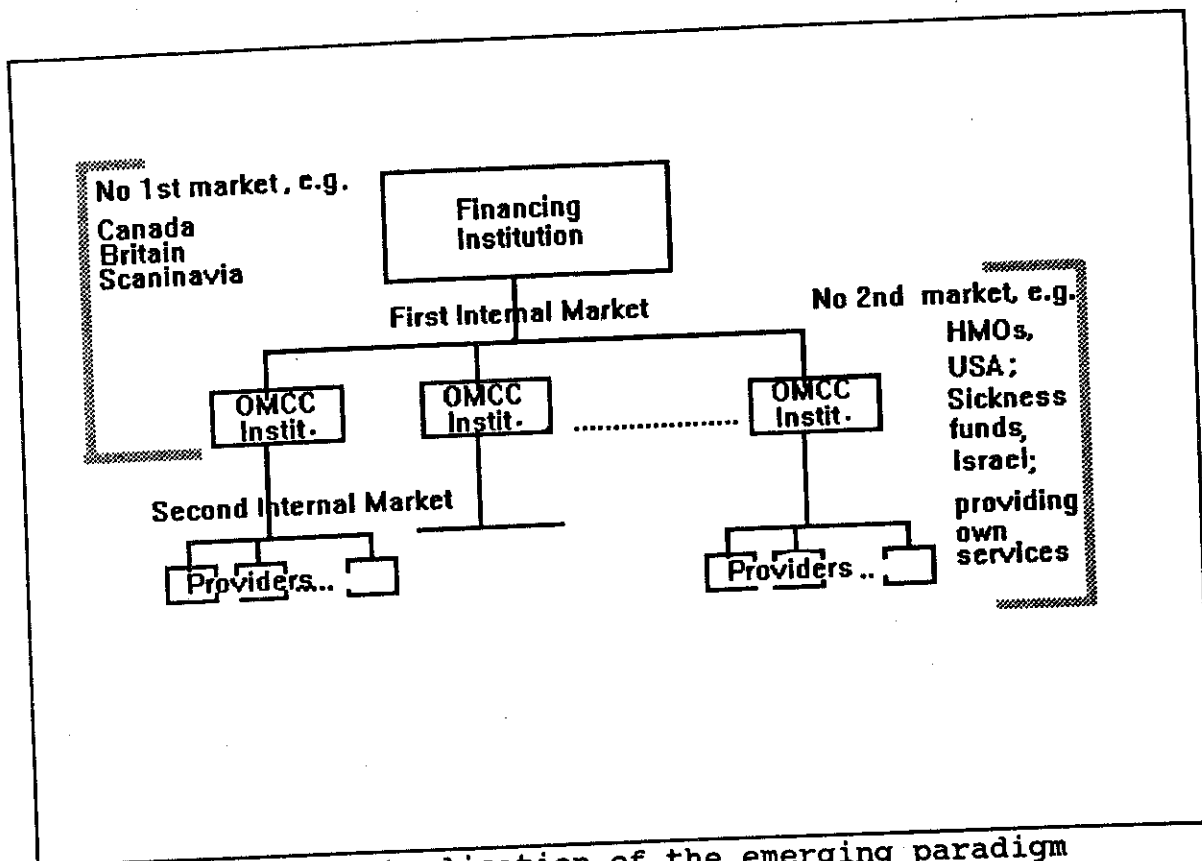


Figure 1: A conceptualization of the emerging paradigm

The emergence of at least two (out of a possible three) segregated system functions governed by distinct market or administration principles, and of two resulting potential markets is illustrated in Figure 1. In the first internal market, competing OMCC institutions offer or sell the same "social package" financed through public finance principles, but in different "packagings" or alternative service options or qualities.⁸ The citizens are the buyers in this market through their endorsement of the public finance allotted to the social package for the OMCC institutions ("packagers" and sellers) of their choice. In the second potential internal market, OMCC institutions procure care on behalf of their constituencies from providers who are the sellers in this particular market.

Under the emerging paradigm, the financing and provision functions are always separated from each other because of the different principles, public versus competitive, guiding each of these functions. Hence, at least one of the two potential markets must exist. Financing and OMCC functions may be integrated, and OMCC and care provision can be integrated; however, all three functions cannot be combined.

Institutional integration of public finance and OMCC functions leads to the elimination of the first internal market described above. The pattern of care consumption is fairly uniform, except for regional difference when applicable, because it is organized and managed by a public administration that reimburses or budgets private and other free-standing — preferably competing — institutions that provide the entitled care to citizens. Examples of such systems are found in Canada, Britain, and Sweden. The Medicaid and Medicare arrangements in the United States, involving free-standing providers, conform to this model.

Institutional integration of OMCC and provision functions leads to institutions that organize and manage, as well as provide, care for consumers. These include the publicly funded Health Maintenance Organizations (HMOs) or the sick funds which provide all care "in house." Hybrids are possible, such as the HMOs which provide some services in their own facilities while procuring other services from free-standing providers. Examples of these systems can be found in Israel, the Netherlands, and the United States. What is important about this type of integration or the scope of the second internal market is that it is the prerogative of the OMCC institution rather than the result of governmental regulation. It is this prerogative that allows the OMCC institution to provide its own 'packaging' of the public or social package, balancing cost-effectiveness and client satisfaction considerations.

While the two potential markets just outlined operate under financing

secured through public finance principles, private financing is also possible - when sanctioned - in conjunction with the subsequent public contract which follows public financing. When the 'first' market does not exist, or when the financing and OMCC functions are integrated under public administrations, private financing options for 'extras' is confined to provision level. While Australia allows for this option, Canada practically prohibits it. When the "first" market exists, or when OMCC institutions are free standing, those institutions may offer insurance for the 'extras' and charge a fee for the services. Such arrangements conform to the Preferred Provider Arrangement in America, resemble pertinent French, German and Dutch arrangements, and are now sanctioned but still debated in Israel under the recent 1994 national health insurance legislation.⁹

11. Despite the wide scope for competition and private sector involvement in the OMCC and in the provision of care, the State shoulders ultimate responsibility for orderly provision of at least the socially determined care package. It does so while trying to safeguard access and quality of care and at the same time promote systemic efficiency within the expenditure limits it attempts to set. This reserves to the State the tasks of: 1) setting policy, 2) collecting and disseminating information, 3) establishing allocation criteria for tax-based funds, 4) regulating access to and quality of care, 5) promoting competition and regulating monopolies and monopsonies; 6) providing guidelines for contracts, including for-fee systems, 7) supporting research and training, and 8) providing for unexpected expenditure for health-related events with social consequences, such as disasters and epidemics.

III. The Clinton Proposal and the Emerging Paradigm

The overall objectives of the Clinton Proposal were fully consistent with those of the emerging paradigm. The Proposal aimed to provide Americans with universal access to a basic package of care, and to cap the unparalleled growth in American health expenditure. At the same time, the Proposal attempted to preserve what is good about the American system (when access is available): quality care and service, and, hence, consumer and provider satisfaction, and presumed efficiency in the production of care.¹⁰

Functionally too, the Proposal accorded with the Paradigm in regard to recognition of systemic functions, notably the OMCC function. The Proposal failed, however, to clearly identify the distinct underlying principles that govern the Paradigm's and, for that matter the Proposal's, different systemic functions. In

other words, the Proposal practically eliminated the clear definition of institutional responsibilities and orderly functioning or administration of any one of the two potential markets making up the Paradigm.

Regarding the financing function, the Proposal stipulated public finance principles, requiring tax-based (for the poor and elderly) and mandatory employers' contributions as means to achieve a measure of equity and to cap costs. Institutionally, the Proposal stipulated creation of a regional Alliance to administer this function. Indeed, this is the only solution for applying public finance principles: pooling all moneys available through some form of taxation and allocating them on some universal principle, usually capitation. However, the introduction of an employer-based Alliance that could be interregional defied these principles and, as is further discussed below, was symptomatic of the Proposal's conceptual confusion.

As for the OMCC function, unlike the Paradigm the Proposal was dubious about the separation of this function from those of both financing and provision. While the Alliance was to assume the financing role, it was also to assume the OMCC function; i.e., it was supposed to negotiate and select specific care "Plans" or provision arrangements on behalf of its regional constituency. Hence, no first market where OMCC institutions compete was stipulated. A lack of clarity regarding the nature of the first internal market resulted in the Clinton administration being forced to establish a *quasi*, but not *real*, second internal market, where the (single) regional Alliance would be the buyer and "Plans" would be the sellers. But this was again inconsistent with the Paradigm which stipulates a citizen's free choice of providers under public contract, especially when they have no free choice of OMCC institutions. There was no *a priori* reason to assume that the Plans chosen by an Alliance, regional or employer-based, would suit all its clients, especially those who come under public contract, but also those who are willing to insure and pay for extras.

In other words, the Alliance was not meant to be a clearly accountable regional administration of a public nature with only a financing role, letting the citizens choose freely amongst competing OMCC institutions such as HMOs and the like, that may, in-turn, open a second market for their clients to choose providers.¹¹ Neither was the Alliance meant to be a public administration with combined financing and OMCC functions that lets citizens choose freely amongst providers that compete in the (remaining) 'second' internal market for publicly financed clients, or for public contracts.¹²

Thus, the Clinton Proposal embraced neither full competitive principles nor full administrative principles with regard to performance of the OMCC function.

Neither did it enable application of competitive principles for the third and most obvious function: provision of care. These principles are a cardinal requirement for the administration of this function under the Paradigm, especially when such principles do not govern the OMCC function.

Paradoxically, in contrast to American tradition, Americans under the Proposal would not be able to freely choose an Alliance (in the capacity of a competing OMCC institution), and would have, at best, a limited choice of providers subject to the Plans selected by the Alliance. While this would be a clear improvement over the existing system for the currently uninsured, it would offer the population at large less freedom of choice for the social package. It would certainly offer less free choice to Americans than citizens in other countries enjoy under the two distinct alternative models possible under the emerging Paradigm, i.e., 1) competing OMCC institutions (e.g., Israeli and proposed Dutch sickness funds, and HMOs and the like under Medicaid and Medicare arrangements), or 2) competing providers under public contract (e.g., the Canadian) system. That is, while under public entitlement, an unemployed Israeli or Dutch citizen can still leave a sick fund and an unemployed Canadian can walk away from providers he or she dislikes, and all three, in their respective systems, can choose another option. The unemployed American would not have a parallel choice under the Clinton Proposal. While under public entitlement, an employed Israeli, Dutch, or Canadian citizen has the same free choice, regardless of place of employment; the American employee would not be able to exercise such choice under the Clinton Proposal, especially if he or she is enrolled in an employer-based Alliance. The American, whether employed or not, would be practically impounded by the Alliance and its limited choice of Plans.

As suggested already, the employer-based Alliance idea is symptomatic of the conceptual confusion of the Proposal. The underlying idea and this particular institutional arrangement might be interpreted as a legitimate right of certain groups of citizens to organize under an OMCC institution to their liking, based on this institution's particular arrangement with providers; but they cannot, at the same time, also assume control over their contributions to the "public pool."¹³

To sum up, the Clinton administration essentially backed away from making a decision that was necessary to avoid confusion, i.e., the decision to clearly separate at least the financing and provision functions and to organize them on the basis of different market or administration principles. It did not decide between either of the two options available under the Paradigm: 1) to establish a regional entity dealing with financing under public finance principles and, in parallel, to allow competing OMCC institutions, thereby creating the first internal market; or 2) to establish a public or quasi-public regional or state financing administrative entity

with the OMCC function, that would relinquish to the citizens a full choice of providers under a public contract. Paradoxically again, the Clinton Proposal offered less choice to the average American, and reflected more micro-management of the system for money collected under public finance principles, than is necessary under the emerging Paradigm.

IV. A Modified Clinton Proposal under the Emerging Paradigm

If the U.S. reform is to follow more closely the principles of the emerging Paradigm and preserve most of the American legacy, it would allow the clear operation of two internal markets with well-defined institutions. Specifically, it would organize the American system as follows:

- a. A regional, state public, or quasi-public financing agency would pool all mandatory private and public funds earmarked for health care finance.
- b. Citizens (through taxes) and employers (through a "wage-bill tax") would contribute to this agency or pool irrespective of employees' and, for that matter, each citizen choice of coverage and OMCC or provider institutions.
- c. Citizens and entitled non-citizens would be allowed to choose an HMO or PPO (an OMCC institution) of their preference, regardless of status and place of employment within the state or region.
- d. The financing agency would reimburse HMOs or PPOs of different types according to enrollment using a universal capitation system.
- e. HMOs and PPOs would contract for provider services, including "services across the regional border," in any way they see fit and would provide 'extra' benefits under either insurance or fee-for-service arrangements.
- f. The government and the financing agency would set policy, monitor operation of the system, mainly combating adverse selection under "public entitlement" of different types, and assure quality.
- g. A federal financial agency, possibly the Federal Government, would equalize opportunities of access to the basic package of care across regions or states.

While preserving the fundamental aims and principles of the original Clinton Proposal, this modified proposal appears to have several advantages. First, it would offer individuals, especially those with access only to the basic package, choice

among competing HMOs or PPOs and, possibly, among providers beyond the choice available through Alliance-selected Plans.

Second, the Proposal, as modified, would be more effective in controlling rising costs, especially to employers. The health system would be "neutral" regarding employers' and employees' considerations: employers would pay on an equitable basis without pressure for extra benefits, and individuals could still pay or insure for extra choice.

Third, the government role in the system would be reduced, in large part due to the fact that the need to regulate the ill-defined Alliances — as well as relations between alliances and Plans — would be obviated.

Finally and most importantly, modifications in line with the emerging Paradigm would preserve the principles of pluralism in the American system. Although there would be a new health finance institution, other institutions making up the American health scene would remain intact. Insurers willing to participate in the scheme could become OMCC institutions, HMOs or PPOs of different types, or they could remain pure insurers of extra benefits. Providers could play their part either within or outside HMOs.

V. Conclusion

Ironically perhaps, the experience being brought together under the emerging Paradigm, with regard to the competitive principles guiding the OMCC and provision functions, are American. The pertinent principles guiding the financing function might be deemed not-American and they probably are not, although they exist under the Medicaid and Medicare programs.

Indeed, from the perspective of the emerging Paradigm or the experience of other industrialized democracies, the United States need not "outdo itself" as the Clinton Administration appeared to propose. Rather, incremental steps focused on financing and entitlement, using the vast experience gained from its current public programs, can align the United States with most other OECD nations. This is not to say that a reformed American system would conform in all aspects to the mold of any one particular current health system.

Notes

1. The White House Domestic Policy Council. *The President's Health Security Plan*. New York, Times Books; 1993.
2. Scheiber, J. G., Poullier, J. P. and Greenwald, L. M. "Health system performance in OECD countries: 1980-1992." *Health Affairs* 1994;13:100-112.
3. For an elaborate discussion of the emerging Paradigm, see Chernichovsky, D. "Reforms in health care systems in industrialized economies; an emerging paradigm." *The Milbank Quarterly*; 1995. In press.
4. Hurst, W. J. Reforming health care in seven European countries. *Health Affairs* 1991;10:7-21.
5. Chernichovsky, D., Barnum, H., and Potapchik, E. 1995. "Health sector reform in Russia; the finance and organization perspectives." Mimeo. Ben-Gurion University of the Negve. Israel. 1995.
6. Chernichovsky, 1995 Op. Cit.
7. Enthoven's 'managed competition' concept is consistent with that of the Paradigm in as much as the latter means competing OMCC and provider institutions operating under public finance principles. Enthoven, A.C. "Managed competition: an agenda for action." *Health Affairs* 1988;8:25-47.
8. Quality here refers to quality of service as perceived mainly by clients, and should not be confused with quality of medical care. Quality of service is largely influenced by amenities and nature of access, including scope of choice.
9. The issue of private finance is beyond the scope of discussion here. See Chernichovsky Op. Cit. 1995, and Chernichovsky, D. "The emerging financial mechanism for reformed health care systems; capitation and its implications revisited." Mimeo. Ben-Gurion University of the Negve. Israel. 1995.
10. There is no empirical evidence that privately-owned care institutions are more efficient than their publicly-owned counterparts. The key contributing factor to production efficiency is method of reimbursement. In a competitive environment, budgetary or input-based methods tend to yield less efficiency than fee-for-service or prospective (e.g., DRG) payment mechanisms. Such mechanisms may be applied both in publicly and privately financed care, and to institutions of all kinds of ownership.

11. Alternatively, one could think in every region of competing Alliances - in the capacity OMCC institutions - financed by a public or quasi-public administration.

12. When competing OMCC institutions do not exist, there is no first internal market. The 'second' internal market in this case is the one in which providers compete for clients who 'assign' to providers contracts with a public administration.

13. This implies 'opting out' — the right to avoid mandatory (public or public-like) payment to the system in lieu of a private alternative. Opting out, where it exists, has been by-and-large eliminated, both in full public finance (commonwealth-type) systems, e.g., Sweden, or in systems with mandatory insurance (continental-type) systems, e.g., the Netherlands. Opting out still exists in Germany, but only for the wealthiest 10% of the population.