Implementing Healthcare Reform: Who, How, and When

BY JANE H. WHITE

Healthcare reform continues to gain increasing visibility during this election year. At the Democratic National Convention in July, candidate Bill Clinton's call for citizens' right to healthcare received one of the most fervent ovations of the evening. Congressional members have introduced dozens of healthcare reform bills over the past year. And President George Bush has set out a reform proposal to help the uninsured gain healthcare coverage via tax credits.

So far, the reform discussion has centered on the basic design of the divergent proposals. Policymakers and analysts are debating who pays, what benefits should be covered, who should be covered, and how to pay hospitals and physicians. Some health policy analysts believe it is now time to look beyond design issues and ask the more probing questions of implementation: What roadblocks do the various proposals face?

Top policy analysts met in Washington, DC, on June 12 to voice concern that implementation analysis is being neglected in the current debate and is necessary to help design "workable" reform. New York City–based New York University (NYU), with support from the Josiah Macy, Jr. Foundation, commissioned papers on various aspects of implementation.

In introducing the meeting, Charles Brecher, professor of public and health administration at NYU, explained, "In essence, [implementation analysis] is trying to figure out what can go wrong before it does. . . . By conducting such analysis in advance, as part of the process of designing alternatives, it is possible to avoid enacting policies that will be difficult or impossible to implement."

This column explores some of the pending implementation issues for healthcare reform raised at the meeting and elsewhere.

The Political Context for Reform

The political context in which any reforms are crafted will have a significant effect on the shape and evolution of such reform. In the lead paper prepared for the NYU-Macy meeting, political scientist Lawrence D. Brown of Columbia University, New York City, argued that "the institutional forces that make reform desirable also make it difficult, and if they cannot stifle change (as they have in the past), they will shape it in ways that muddy the connections between programmatic means and policy ends."[1]

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In other words, the various parties involved in healthcare (providers, payers, insurers, consumers) all have reasons for wanting to reform the current healthcare system, but each group has strongly differing views on the direction and implementation of any reform. Thus, as Brown noted at the meeting, "Choosing your strategy [for reform] is to choose your enemy" of change. Bringing these groups together and forging "political peace" around a plan of action will be one of the most difficult aspects of implementing healthcare reform, he said. Brown set out five features of the U.S. political environment for healthcare that will shape the implementation of any reform (see **Box**).

Beyond these political factors affecting healthcare reform, three key implementation questions stand out:

- Who will run the reformed system?
- How will cost be controlled?
- How will providers' and consumers' concerns be addressed?

Who Will Run the System?

Given the fragmentation of the current healthcare system and the mistrust of and divisions in government, a key implementation issue to be resolved is, Who will administer new healthcare reforms? Will a public-private mix continue? Will government take more responsibility? Should government responsibility be centered federally or dispersed locally? In other words, who can be trusted to run the system? If the opinions of the nation's elderly are any indication, it is "none of the above," said John Rother of the American

Association of Retired Persons (AARP), Washington, DC, at the June meeting.

Beyond who can be trusted is the issue of accountability. "It's governments' job to make sure accountability is there, since they are pushing reform. . . . We need to merge trust with accountability," commented political scientist Judy Feder of Georgetown University, Washington, DC, at the NYU-Macy meeting.

Political scientist James A. Morone of Brown University, Providence, RI, presented a paper describing the organizational environment and challenges of implementing healthcare reform at the meeting.[2] He provided a checklist of six conditions necessary for effective implementation (see **Box** on next page).

Morone argued with commentators at the meeting about the role of federal and state governments in healthcare reform. "The whole idea that we have a laboratory in the states is not true. We don't give states enough latitude," he said. A number of analysts pointed to Canada's province-by-province healthcare system as a model to follow. However, the provinces "had a level of latitude that's unimaginable here," countered Morone. He did concede that "states can play a major role in a reformed health system," although he does not believe Americans can "look to states to get us out of this mess."

Many state leaders testified about the need to widen their latitude to carry out new reforms.

Many state leaders, on the other hand, testified before Congress that same month about the need to widen their latitude and increase their flexibility to carry out new healthcare reforms. At a June 15 hearing before the Senate Finance Subcommittee on Health for Families and the Uninsured, governors, congressional representatives, and state policy analysts pushed for changes in federal statutes and regulations and for a streamlined waiver process. In addition, a group of 14 governors met with congressional leaders and administration officials June 16 to lobby for support.

"If consensus cannot be reached on a national reform plan this year, flexibility must be given to the states that are ready to pursue their own reforms," testified Florida Governor Lawton Chiles. "The experience we are gaining as we move ahead with our own reform efforts is a resource that you cannot afford to ignore."

In addition to Hawaii's well-established plan for universal healthcare coverage, several states—Florida, Minnesota, Oregon, and Vermont—have

POLITICAL FEATURES SHAPING IMPLEMENTATION OF REFORM

Fragmented Political Structure

Divisions between the political interests of Congress and the administration increase the "likelihood that legislation will incorporate confusing compromises born of the need to satisfy multiple power centers," explained political scientist Lawrence D. Brown of Columbia University at the June 12 NYU-Macy meeting.

The historically strong role for states and localities in healthcare further fragments political power. The American preference for private-sector solutions leads to a public-private split in power. And the lack of a corporatist bargaining structure—where key government agencies and provider groups can engage in structured negotiations, as in some European healthcare systems—is a flaw born of Americans' "widespread distrust of bureaucracy and disdain for 'interest-group liberalism,'" according to Brown.

Voluntary Institutional Core

The deep distrust of government, long part of the American political pysche, has grown even stronger during the current election year. Against this political backdrop, healthcare in the United States has emerged as "a desirable set of private services best financed and delivered by cooperation among voluntary institutional partners at the community level," noted Brown. In contrast, other countries with universal health insurance see an important governmental role for ensuring healthcare access.

Public Programs

The public health programs that do exist (Medicare and Medicaid) are at the same time peripheral and central to the political context for healthcare reform. "The weakening of their coverage is a prime spur to federal action, but their boundless cost horizon is a major barrier to reform," suggested Brown.

Quest for Rationalization

The past two decades of unsuccessful experimentation with both competition and regulation in healthcare have led to much political rationalization of the emergent "public-private mix whose main virtue was that it seemed less unsatisfactory than the available alternatives," noted Brown.

New Affordability Crisis

After 20 years of failed cost containment, a new crisis of affordability has emerged not only among the uninsured but also among fearful middle-class voters. Concerns about rising healthcare costs and the percentage of the gross national product devoted to healthcare stayed on an abstract plane as long as people's insurance provided price insulation. "We have now moved on to a price crisis," said Brown at the meeting. The political pressures from this "will continue to build," he predicted.

recently adopted comprehensive reforms. The National Governors' Association predicts that a number of other states will approve reform plans by January 1993.

Sen. David Pryor, D-AR, and Sen. Patrick Leahy, D-VT, plan to introduce legislation "to encourage state-based comprehensive reforms by cutting federal red tape and giving states the waivers from the federal government they need to reach their goals," said Leahy at the June hearing. The legislation would allow up to 10 states to serve as demonstration sites, granting flexibility in designing healthcare reform plans.

How Will Costs Be Controlled?

Over the past two decades, two seemingly competing strategies have emerged in the quest to control healthcare costs: (1) federal regulatory controls over price and volume and (2) a competitive, market-oriented approach. At the NYU-Macy meeting Kenneth E. Thorpe of the University of North Carolina at Chapel Hill explained that under a regulatory approach, four implementation models emerge for reform.[3] These include:

- A congressional model, where "all healthcare spending would be authorized by annual congressional decisions"
- Formula-based increases, where "the formula would link yearly changes in health care spending to a normative index, such as projected GNP growth or changes in the consumer price index"
- A congressional model with advice from expert panels that are similar to the Prospective Payment Assessment Commission
- An independent board, similar to the Federal Reserve Board or Federal Trade Commission

Thorpe argues that pitting the regulatory strategy against the competitive approach may be a false dichotomy.

For cost-containment success under the market-oriented approach, four implementation requirements emerge, according to Thorpe:

- The federal government must cut or restrict the federal tax subsidy for employer-provided health insurance.
- Since vigorous competition would likely eliminate the current "safety net" for the uninsured and underinsured, "a market-oriented approach requires that a public [income-related] subsidy be provided the poor to secure health insurance."
- The federal government must regulate the insurance market.
- Healthcare providers and consumers must be divided among competing plans rather than simultaneously participating in several organizations.

Both approaches require substantial changes from the status quo. Indeed, Thorpe argues that pitting the two strategies against each other may be a false dichotomy. In a recent paper that has aroused controversy among policymakers, Thorpe and Physician Payment Review Commission Executive Director Paul Ginsburg expand on this notion and propose that a regulatory, all-payer, rate-setting strategy and competition may successfully coexist along the path to a reformed healthcare system. They write:

> Rate setting can be highly compatible with the most important aspects of competitive approaches, but only if it is designed to be so. The key is the degree of freedom that competitive health plans have to contract with providers. . . . If use of all-payer rates by "qualified" competitive plans is made an option, then all-payer rate setting would be compatible with competitive approaches.[4]

How Will Concerns Be Addressed?

At the NYU-Macy meeting, Mitchell T. Rabkin and Eugene C. Wallace of Beth Israel Hospital in Boston raised a number of concerns facing providers in the implementation of healthcare reform. They suggested that "the major reform element affecting providers . . . will not be funding sources or scope of coverage—it will be the character of the provider payment system."[5] For both hospitals and physicians, "there is little

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CONDITIONS FOR EFFECTIVELY IMPLEMENTING REFORM

James A. Morone of Brown University claims six conditions are necessary for effective implementation of healthcare reform ("Administrative Agencies and the Implementation of National Health Care Reform," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992).

- **Goal:** "Does the new policy have a clear goal?"
- **Hypothesis:** "Does the legislation incorporate a sound theory or hypothesis about the way a problem is to be solved?"
- **Administrative Organization:** "Is the agency or agencies chosen to administer the program appropriate to its goals?"
- **Leadership:** "Are the organization's leaders skilled and committed to the program?"
- **Interagency Dynamics:** "Does the agency work effectively with other organizations that are necessary to accomplish programmatic goals?"
- **Technology:** "Does the agency have the appropriate repertoire or 'technology' for the task at hand?"

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ed so that revenue attributable to that off-site center would be appropriately reported.

Another example concerns the recording of employee benefit expenses. The institution must decide whether those expenses will be reported in a single cost center or in the department where individuals worked; however, the numbers for each expense would be the same regardless of the department in which the expense is reported. Such a decision should reflect the institution's human resource management philosophy, not the accounting preference, and thus the human resource department should help decide how to structure this portion of the chart of accounts. The decisions made should facilitate both the way departmental managers and human resource managers relate to individuals and how they are held accountable for expenditures.

Facilities should avoid designing charts of accounts to accommodate board preferences for reporting assets and equity. Different methods of reporting are more appropriate vehicles for meeting board needs. A financial reporting system based on a chart of accounts is a management tool. It should help those within the institution make good operating decisions based on easily understood information.

Board decisions, on the other hand, address policy and strategy issues. Thus board requests are more properly met with reporting outside that which results from the accounting records, and the chart should not be designed to meet these requests.

Time Well Spent

Providers may have neglected the design of the chart of accounts because other concerns have been more pressing. Taking the time to bring managers together to examine these questions may help all involved better understand the structures and relationships within the institution. Creating a chart of accounts that supports such relationships will be time well spent. □

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doubt that the way care is paid for influences the behavior of providers," they continued. Other concerns they cited include autonomy, patient advocacy, external regulations, paperwork, and professional development.

On the consumer side, choice is a key issue. Some market-oriented reforms allow consumers to choose the most efficient, cost-effective healthcare plans. Other plans take a more paternalistic view toward patients and limit choices. AARP's Rother said, "I'm tired of this either-or debate. Clearly there is going to be a regulated system, but we want to see some consumer choice" in it. In implementing healthcare reforms, we "need to look at *which* choices we make consumers responsible for," he continued.

Has the Time Arrived?

Although few policy analysts believe significant healthcare reform will be forged during this election year, many think it *will* happen eventually. Legislators are hearing calls for reform from their constituents at both the state and federal levels. Many states are actively pursuing and implementing reforms. Provider groups have stepped up their level of debate on reform. The Catholic Health Association (CHA), for example, plans to devote considerable energy this coming year to education forums on its new reform plan and is working on an implementation strategy. "We will have healthcare reform when middle-class Americans are so frustrated with the risk segmentation [of the current system] that they say to their member of Congress, 'Don't come home without a plan,'" said Bill Cox, CHA's vice president for government services.

"I surmise we have turned some sort of corner that will accelerate change," suggested Brown at the June meeting. The current debate between "comprehensive versus incremental change is a false dichotomy. We will proceed incrementally," he added. "If, however, the commitment to affordable universal coverage stays strong, one increment will lead to further ones, and it will be difficult to stop the action short of 'fundamental' change over a decade or two." □

NOTES

1. Lawrence D. Brown, "Getting There: The Political Context for Implementing Health Care Reform," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992.
2. James A. Morone, "Administrative Agencies and the Implementation of National Health Care Reform," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992.
3. Kenneth E. Thorpe, "Cost Containment and National Health Care Reform: Implementation Issues," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992.
4. Paul Ginsburg and Kenneth E. Thorpe, "Can All-Payer Rate Setting and the Competitive Strategy Coexist?" *Health Affairs*, Summer 1992, pp. 73-86.
5. Mitchell T. Rabkin and Eugene C. Wallace, "Provider Concerns and the Implementation of Health Care Reform," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992.