UNLV EPS 701 Fall 1994, Argument Analysis Paper

A Better Quality Alternative: Single-Payer National Health System Reform

Gordon D. Schiff, MD, Andrew M. Bindman, MD, Troyen A. Brennan, MD, JD, MPH; for the Physicians for a National Health Program Quality of Care Working Group.

JAMA, September 14, 1994—Vol 272, No. 10

by

Robert E. Gladd

December 15, 1994

UNLV EPS 701 Fall 1994, Robert E. Gladd, Argument Analysis Paper

A Better Quality Alternative: Single-Payer National Health System Reform

Gordon D. Schiff, MD, Andrew M. Bindman, MD, Troyen A. Brennan, MD, JD, MPH; for the Physicians for a National Health Program Quality of Care Working Group.

JAMA, September 14, 1994—Vol 272, No. 10

Definitions (roughly in the order in which the terms appear):

single-payer system - A system of financing and administering health care expenditures through a single government institution funded by taxes. For example, in the Canadian system, all citizens are covered by birthright. Medical providers (physicians, clinics, hospitals, etc.) are a mix of for-profit *and* non-profit entities paid according to publicly established fee schedules.

zero-sum - Any system in which a measurable addition to any component must be accompanied by equal deduction(s) from any other component(s), so that the total net measurable attribute stays constant (in this case health care funding).

universal access - used in this paper as a synonym for "universal coverage," meaning automatic enrollment of all citizens in a health care system, by entitlement.

iatrogenisis, iatrogenic - injuries or other adverse events (such as contracting pneumonia) suffered by a patient while in a hospital for treatment of unrelated illness or injury.

epidemiologic - epidemiology is the study of the origins, patterns, and outcomes of illness

variation - in the context of this paper, variation refers to the statistical attributes of pertinent measures of a process. For example, researchers examine differences in mortality rates for a variety of conditions and treatments, to ascertain whether the differences can be attributed to assignable causes rather than just chance outcomes.

managed competition - a system of private health care delivery wherein overall budgets would be set for a period (i.e., by the government), and providers would compete to maximize profits by providing the most efficient, cost-effective services.

capitation - a health care payment system under which providers receive a fixed payment or "premium" per period for each enrollee. If the enrollee's health services expenses exceed the capitated fee, the provider suffers a loss, and conversely. This is the structure of the "HMO," or Health Maintenance Organiztion model. The opposite of "fee-for-service."

Medicare - The government administered health insurance system for retirees and certain disabled citizens. Paid for by the Medicare portion of Social Security tax collections.
Medicaid - The government administered health insurance system for U.S. citizens defined as "impoverished." Funded jointly by the federal and state governments, and administered by state agencies.

Agency for Health Care Policy Research (AHCPR) - Federal national medical policy research arm of the U.S. Health Care Financing Administration (Dept. of Health & Human Services).

Joint Commission on Accreditation of Health Care Organizations (JCAHO), Agenda for Change program - Hospital accrediting agency program which approves provider cooperative quality improvement research projects as a component of accreditation.

Medicare's Health Care Quality Improvement Initiative (HCQII) - A national program involving the state-based non-profit Medical Peer Review Organizations (PROs) which engages health care providers in local, statewide, and regional research projects designed to improve care processes and outcomes.

diastolic (blood pressure) - the blood pressure measured during the relaxation phase of heart muscle cycles (opposite of systolic).

hemoglobin A_{1c} - iron-containing blood component, the measurement of which is an indicator of glucose (blood sugar) regulation in diabetics.

diabetic, diabetes - disorder of carbohydrate metabolism characterized by inadequate internal insulin production.

Papanicolaou test - the "Pap smear," a lab test for cervical cancer.

glaucoma - internal eye disorder resulting in pressure on and atrophy of the optic nerve, often leading to blindness.

co-payments - the portion of a patient's routine medical benefits not covered by the insuror and owed directly by the patient.

emphysema - chronic, cell-degenerative lung disorder.

utilization review - auditing of medical cases for appropriateness of admission and/or treatment. Can be retrospective, or "concurrent" (i.e., where a patient would have to obtain insuror authorization for admission to the hospital).

serology - laboratory analyses of blood samples.

claims data(bases) - patient transaction records comprised of demographic data, diagnostic and procedural codes, and billing and related administrative information (as opposed to "clinical data(bases)" which would contain physical & lab data).

hematocrit - the proportion of total blood volume comprised of red blood cells.

diagnosis creep - where treatment payment is contingent on the diagnostic and procedural codes used to document patient medical records, providers have a financial incentive to "code up" by using discretionary codes that have the highest payment weights, without resorting to fraud.

CQI (Continuous Quality Improvement) - The currently favored paradigm of quality improvement which eschews retrospective inspection/auditing in favor of continual measurement and re-evaluation of key process steps within an organization, applying scientific experimental principles to process improvements.

outliers - a measurement point far enough distant from an expected or "mean" (average) value as to be deemed highly unlikely to occur by pure chance, warranting closer investigation for remediable causes.

practice guidelines - regarded skeptically by many physicians as "cookbook medicine," the application of clinical research-based standard procedures to the diagnosis and treatment of illness.

fee-for-service - health care payment system wherein each diagnosis, lab test, supply, and/or procedure is billed to the patient or insuror.

carotid endarterectomies - surgical removal of blocked carotid arteries.

hypertension - high blood pressure.

human immunodeficiency virus (HIV) - the virus known to cause AIDS, Acquired Immuno-Deficiency Syndrome.

ADDITIONAL TERMS & PHRASES:

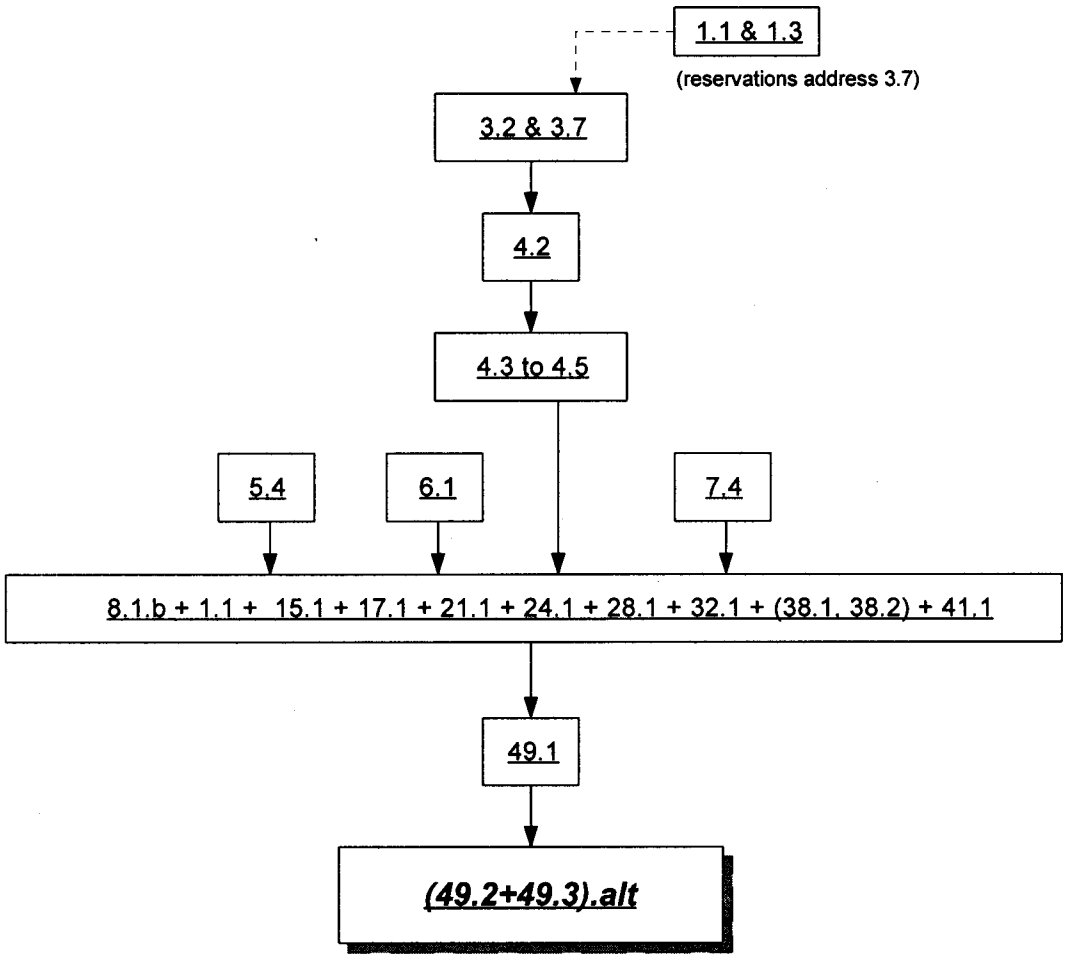
Medi-save account - a proposed method of health care financing reform in which employed people would directly receive the funds now spent on their behalf for health insurance coverage by their employers, and would be required to place the money in private accounts from which they would pay for routine health care services, with part of the funds allocated to the purchase of much less expensive "catastrophic" insurance coverage. These funds would be tax exempt, much like those of the widely used Individual Retirement Account (IRA). Indeed, they have often been referred to as "medical IRA's." Account funds not needed for health care during the calendar year would be convertible to the employee's general use. The idea is to give individuals direct control over and responsibility for routine health care spending. The hope is that they would thereby become more efficient purchasers of medical care.

community unsurance rating - a proposed method of controlling health insurance premium costs that would by law or regulation prohibit insurors from charging individuals with possibly high risk factors more than a restricted percentage above "community" norms. The opposite of "*experience rating*," the traditional, actuarial method of calculating risk, setting rates, and excluding unacceptably high risk applicants from coverage.

actuarial - those activities pertaining to estimation of risk probabilities based on historical, or "empirical" (statistical) data such as death, disease, and injury rates and their associated costs.

OVERVIEW:

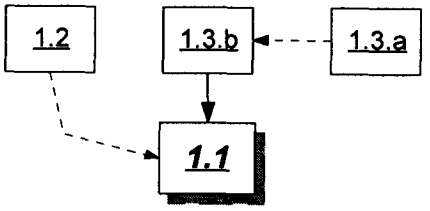
Essential logical elements of the argument in this paper



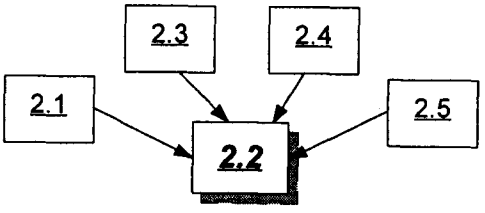
Argument synopsis:

Notwithstanding public misgivings about making significant public policy driven changes in the U.S. health care industry, there is extensive and persuasive empirical evidence of costly inadequacies in the system—such as lack of access/coverage, uneven levels of quality of service and outcomes, market-driven rather clinical priorities, waste and duplication, etc.—that can best be corrected by a unified approach to improvement driven by a scientific focus on quality issues (broadly defined) rather than those of short-term cost-control, competition, and piecemeal regulatory strategies and tactics. A single-payer health care system reformed by implementation of the ten principles detailed herein would at once extend medical access to all, reduce costs, improve clinical outcomes of the sick and injured, and elevate the overall health status of the nation, resulting in win-win consequences for providers and citizens alike.

1.1:
Many misconstrue U.S. health system reform options by presuming that "trade-offs" are needed to counterbalance the competing goals of increasing access, containing costs, and preserving quality.[1,2]
1.2:
Standing as an apparent paradox to this zero-sum equation are countries such as Canada that ensure access to all at a cost 40% per capita less, with satisfaction and outcomes as good as or better than those in the United States.[3,4]
1.3:
[.a] While the efficiencies of a single-payer universal program are widely acknowledged to facilitate simultaneous cost control and universal access, [.b] lingering concerns about quality have blunted support for this approach.



2.1:
Quality is of paramount importance to Americans.
2.2:
Opponents of reform appeal to fears of diminished quality, waiting lists, rationing, and "government control."[5]
2.3:
Missing from more narrow discussions of the accuracy of such charges is a broader exploration of the quality implications of a universal health care program.
2.4:
Conversely, advocates of national health insurance have failed to emphasize quality issues as key criteria for reform,[6] often assuming that we have "the best medical services in the world."[7]
2.5:
They portray reform primarily as extending the benefits of private insurance to those currently uninsured, with safeguards added to preserve quality.



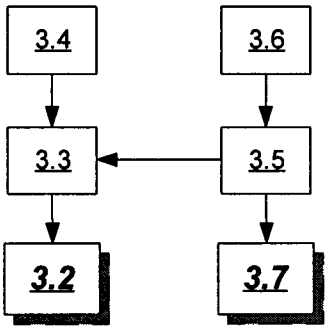
3.1:
We disagree with both views.
3.2:
It is unthinkable to label our current system as "highest quality" given its frequent failure to provide such basic services as immunizations or prenatal, primary, or preventive care.
3.3:
Moreover, there is growing concern about quality problems with the care that is provided.
3.4:
Quality problems in the current system include denial of care, discrimination,[8] disparities, geographical maldistribution,[9] lack of continuity, lack of primary care,[10] inadequate or lack of

prenatal care,[11] failure to provide beneficial prevention,[12] substandard/incompetent providers,[13] declining patient satisfaction and impersonal care,[14,15] iatrogenesis (negligent adverse events),[16] diagnostic errors,[17] unnecessary procedures/surgery,[18] suboptimal medication prescribing/usage,[19] and neglect of quality-of-life/psychosocial issues.[20]

3.5:
Our "highest-quality" complacency is especially challenged by insights from two seeming disparate sources: (1) epidemiologic research based on financial claims databases and (2) industrial quality improvement concepts pioneered in Japan.

3.6:
These two sources converge around the concept of "variation," illuminating widespread differences in clinical practice, further challenging the cost-access-quality tradeoff assumption.

3.7:
Data and insights from these two new paradigms demonstrate that better care will actually cost less once improvements are made in care processes and clinical decision making.[21,22]



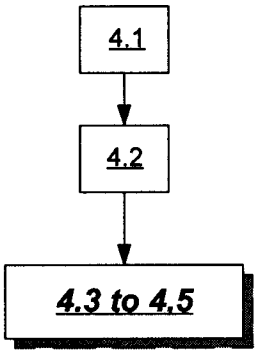
4.1:
The health system must work better to extend access and to control costs.

4.2:
In this article, we argue that a single-payer national health program provides a better framework for improving quality.

4.3:
First, we briefly review requirements for improving quality.

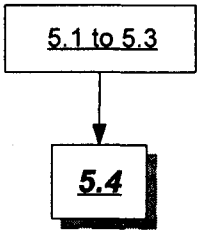
4.4:
Then, we propose 10 principles that should be integral to reform strategies to augment quality.

4.5:
We contrast our approach with the current managed competition[23] strategy, showing how a single-payer system is more likely to facilitate these 10 interrelated quality features.

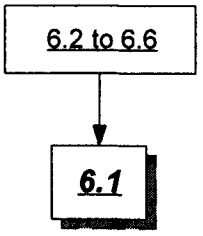


WHAT IS QUALITY? HOW CAN IT BE MEASURED?

5.1:
High-quality care should result in improved health for individuals and the entire community.
5.2:
It depends on knowledgeable, caring providers who have a thorough understanding of preventive, diagnostic, and therapeutic strategies and the link between their application and improved health outcomes.
5.3:
Such strategies need to be applied with the highest technical skill and carried out in a humane, culturally sensitive, and coordinated manner,
5.4:
Quality will suffer when any of these components is lacking.

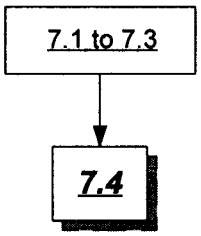


6.1:
These is no single standard measurement of health care quality; its assessment requires multiple perspectives.
6.2:
The care provided to the population as a whole as well as to individual patients should be evaluated because critical quality issues may affect individuals who do not have access to medical services.
6.3:
Viewpoints of providers, patients, family members, and the community must be incorporated.
6.4:
Evaluated services should not be limited to medical care but should also include related services, such as nursing services, social services, and community education.
6.5:
To judge quality, we need a lengthened time frame that allows not only for examination of longer-term impacts but also for changes over time in what is considered good care.
6.6:
Finally, quality should be judged in the context of costs, because when equally good care is provided at a lower cost, more resources are made available for other services.



7.1:
Although consensus has emerged around many of these precepts,[24,25] there is disappointment over the extent to which their fragmented application has actually improved care.[26,27]

7.2:
This meagerness of demonstrated benefit is especially worrisome given providers' frustration with the time and administrative burdens imposed by current oversight measures.
7.3:
Promising efforts to operationalize these precepts on a larger scale (i.e., Agency for Health Care Policy Research, the Joint Commission on Accreditation of Healthcare Organization's Agenda for Change, and Medicare's Quality Improvement Initiative)[28] will continue to have limited success if not linked to more fundamental changes in health care finance and delivery.
7.4:
This will require health system reform based on the application of quality assurance tools and insights, guided by the principles outlined below.



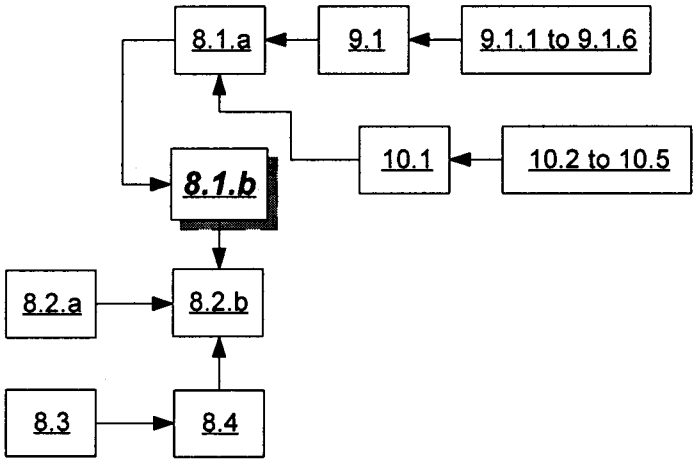
TEN PRINCIPLES FOR IMPROVED QUALITY

8.1:
1. [.a] There is a profound and inseparable relationship between access and quality: [.b] universal insurance coverage is a prerequisite for quality care.
8.2:
[.a] Because quality must be population-based, [.b] traditional definitions of quality should be broadened to include the gravest of quality deficits—denial of care.[28]
8.3:
The most important prerequisite for access is health insurance.
8.4:
To delay universal coverage for years, as projected in the Clinton plan and various congressional health proposals, means the continuation of compromised quality for millions of people.

9.1:
Growing evidence from large observational studies underscores this strong relationship between quality and access/insurance status:
9.1.1:
The hospitalized uninsured are 2.3 times more likely to suffer adverse iatrogenic events.[29]
9.1.2:
The loss of Medicaid coverage has been associated with a 10-point increase in diastolic blood pressure and a 15% increase in the hemoglobin A_{1c} level in diabetic patients, increasing the odds of dying within 6 months by 40%.[30]
9.1.3:
The uninsured poor are twice as likely as those with private insurance to delay hospital care; among those delaying care, hospital stays are longer and death rates are higher.[31]
9.1.5:
Being uninsured was associated with twice the 15-year mortality (18.4% vs 9.6%); even after adjusting for major risk factors, mortality remained 25% higher.[32]

9.1.6:
Lack of health insurance is associated with failure to receive preventive services, including blood pressure monitoring, Papanicolaou tests, breast examinations, and glaucoma screening.[33]

10.1:
This profound connection between quality and access extends far beyond simply underserving the uninsured.
10.2:
Access problems threaten quality for those with insurance who can encounter delays and overcrowding in emergency departments overflowing with patients lacking primary care.[34]
10.3:
For the insured, limitations on benefits, including financial barriers (such as co-payments, restrictions in coverage, and rationing via administrative obstacles), increasingly obstruct care.[35]
10.4:
More important, quality is distorted when ability and willingness to pay become the criteria for determining which services are provided.
10.5:
Marginally effective or even harmful treatments for the well-insured affluent take priority over more needed and appropriate services.[36]



11.1:
2. The best guarantor of universal high-quality care is a unified system that does not treat patients differently on the basis of employment, financial status, or source of payment.
11.2:
This principle embodies Eddy's health care "golden rule": If a service is necessary for oneself, it is necessary for others.[37]
11.3:
We reject the notion that different people are entitled to a different quality of care.

12.1:
The quality-impairing consequences of separate classes of insurance are illustrated by Medicaid, whose recipients, though "insured," are often refused care or provided substandard treatment.[38]
12.2:
For many medical services, access for Medicaid patients is little better than for the uninsured

(D.U. Himmelstein and S. Woolhandler, unpublished tabulations from the 1987 National Medical Expenditures Survey).

12.3:
Similarly, universally available lowest-tier coverage, such as that proposed under managed competition, with more or better services only for those able to afford to upgrade their benefits, violates this principle and would perpetuate inequalities in health care.

13.1:
The equality principle is a prerequisite to grapple meaningfully with ways to control marginally effective expensive interventions.

13.2:
Otherwise, limits based on ability to pay are, by definition, discrimination against the poor.[39]

14.1:
Under a multitiered system patients and providers internalize an "everyone for himself or herself" ethic, eroding incentives for improving the system overall.[40]

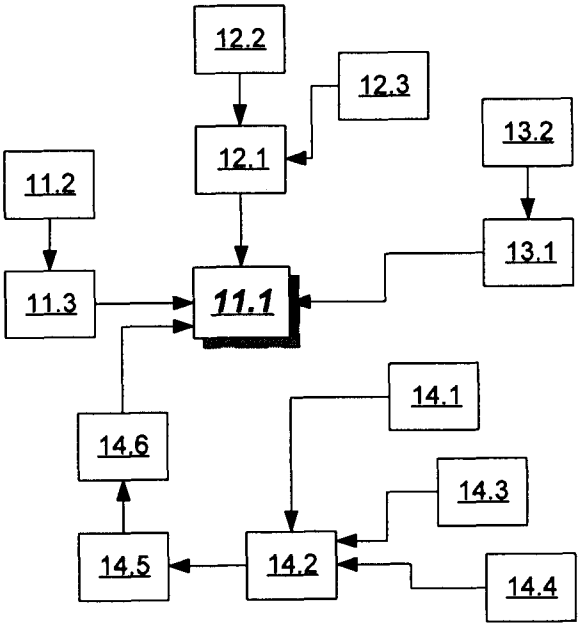
14.2:
A cohesive system based on fairness and equality could harness each citizen's desire for quality care to drive system quality upward.

14.3:
It wood promote mechanisms for individual complaints to be linked to system-wide improvement, rather than dissipated as special privileges.

14.4:
It would ensure that the quality of the basic plan is high enough to be acceptable to all citizens.

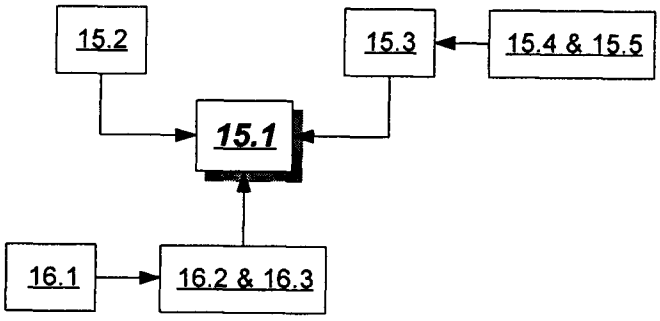
14.5:
Proposals that allow individual or corporate "opting out" of publicly defined benefits packages erode this quality-enhancing covenant.

14.6:
Hence, a single program not only minimizes discrimination against the vulnerable but also promotes improvement overall.



15.1:
3. Continuity of primary care is needed to overcome fragmentation and overspecialization among health care practitioners and institutions.
15.2:
Patients need care coordinated by the primary care provider of their choice.
15.3:
Whether evaluating a confused elderly patient or discontinuing aggressive care to a patient with emphysema, a continuing physician-patient relationship is the essential foundation that allows physicians to practice conservative, sensitive, appropriate, cost-effective medicine.
15.4:
Competitive models that encourage patients to switch among competing plans discourage ongoing relationships.[41]
15.5:
Competition also blunts incentives for prevention because the resulting savings are likely to accrue long after the patient has switched to a rival plan.

16.1:
As practitioners, we do quality work when patients can trust that we will be available with the time, independent judgment, and familiarity with their problems to give them skillful personal attention.
16.2:
Cost-containment efforts designed to limit utilization have counterproductively undermined this primary caring role.
16.3:
Erecting financial barriers to discourage contact, penalizing the primary practitioner for ordering tests and consultations, and intrusive utilization review measures have contributed to growing dissatisfaction with primary care practice.[42,43]



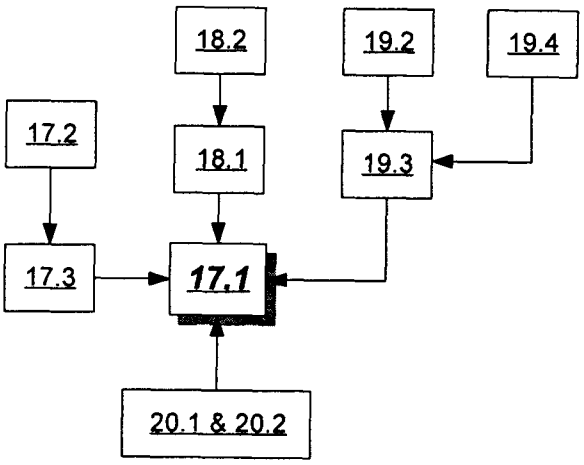
17.1:
4. A standardized confidential electronic medical record and resulting database are key to supporting clinical practice and creating the information infrastructure needed to improve care overall.
17.2:
Information technology should allow us to zoom in to focus on the microdetails of why a particular clinical decision was made, as well as give a macro-overview disease patterns in populations.
17.3:
Its memory should permit panning backward and forward in time, seeing our own patients'

past histories, as well as aggregating data to project disease natural history and response to interventions.

18.1:
Unfortunately, implementation of medical computing has been driven by insurance/billing imperatives, often ignoring information needs for improved patient care.
18.2:
The Institute of Medicine Committee on Improving the Medical Record has documented the ways that paper-based medical records and computerized laboratory and claims data fail to coalesce into integrated patient care records, capable not only of storing patient data but also of improving the quality of care.[44]
18.3:
Consider routine, yet currently difficult clinical decisions, such as whether a patient's wound requires a tetanus shot, or a positive syphilis serology result requires treatment, or a decreased hematocrit requires further workup.
18.4:
Computer technology should permit us to track over time across multiple sites and support higher quality clinical decision making.
18.5:
Its potential for real-time reminders, prescribing, and bibliographic assistance is vast but unrealized.[44,45]

19.1:
Realizing the computer's quality support potential hinges on strong guarantees of personal data confidentiality,[44] uniformity and integrity of data systems, availability of aggregate data in the public domain,[46] and minimization of costs, especially for software development and data acquisition.
19.2:
Creating national standards for protection of patients' privacy is one of the most important issues that health system reform must address, yet prospects for federal leadership appear to be confused and uncertain.[47,48]
19.3:
The United States lags behind other countries in developing a secure clinical information infrastructure because it lacks a unified approach.
19.4:
No public entity has sufficient scope or authority to spearhead this project.[49]

20.1:
Despite a lengthy section on information automation, the Clinton proposal perpetuates the primacy of financial data to the neglect of clinical information by calling for computerized billing but not computerized patient care records.[50]
20.2:
Furthermore, managed competition compromises for advancing the public's health by fragmenting information among competing health plans and creates incentives for distortion (i.e., "diagnosis creep") that arise when data are linked to financial rewards.[51]



21.1

5. Health care delivery must be guided by the precepts of continuous quality improvement (CQI).

21.2:

Improved data combined with statistical thinking permit a more scientific practice of medicine.

21.3:

Five ideas are basic to CQI:[22,52,53]

21.3.1:

Systems improvement: addressing underlying causes rather than inspecting for and micromanaging individual practice variations.

21.3.2:

Teamwork and cooperation: shift from fear, individual blame, and competition toward cooperation to improve interactions within and between organizations.

21.3.3:

Overriding commitment to quality: quality should be the foremost mission and central preoccupation of health system leaders and reform efforts; cost savings derive from this primary commitment to quality.

21.3.4:

Improvement of processes: quality can be continually improved by study, innovation, and simplification of the numerous small steps involved in performing daily tasks, leading to an organizational atmosphere of experimentation and productive change.

21.3.5:

Empowerment of workers and customers: frontline workers must have the authority, resources, and statistical tools to conduct process improvements.

21.3.5.1

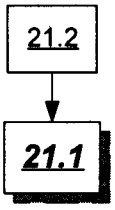
Patients' voices must be amplified so that their needs can be better addressed as the central aim of health care.

22.1:

Current widespread endorsement of CQI belies a continuing focus on external inspection, short-term financial gain as the measure of success, inefficient cost-control measures, and disruptions of physicians' relationships with patients and colleagues as employers and insurers seek the lowest price (*New York Times* , January 24, 1993:1).[22,41,43,54]

22.2:
Under our current system, each insurer must protect its financial stake through these shortsighted measures that disrupt overall quality.
22.3:
Well situated to exercise such undesirable options, insurers cannot risk the long-term commitments to patients and providers, plus loss of management prerogatives, inherent in the five elements of CQI.

23.1:
Improving individual providers' care can best be accomplished via supporting their ability to practice quality care coupled with pooled outcomes data and patient feedback.
23.2:
This contrasts to the current punitive, exclusionary, and competitive approaches.
23.3:
The thrust of CQI is to improve the norm of performance rather than to merely identify outliers.
23.4:
Where individual competence and performance deficiencies do exist, they must be conscientiously and definitively resolved.
23.5:
Continuous quality improvement creates a climate and provides tools to accomplish this more fairly and constructively.



NOTE: in this section, 21.3 through 23.3.5. are not premises, they merely enumerate th attributes of the authors' definition of CQI.

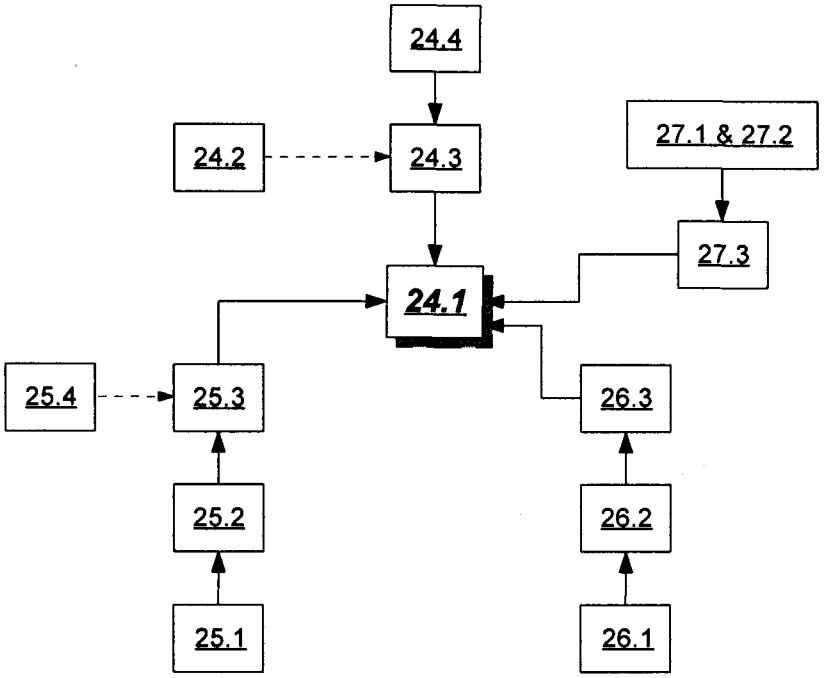
24.1:
6. New forums for enhanced public accountability are needed to improve clinical quality, and to address and prevent malpractice, and to engage practitioners in partnerships with their peers and patients to guide and evaluate care.
24.2:
Patients' and practitioners' mutual desire to redress and prevent suboptimal medical outcomes should make them natural allies.
24.3:
Instead, we are witnessing growing antagonisms.
24.4:
The narrow emphasis on antagonistic all-or-none approaches, such as lawsuits, or exiting one plan for another, constrains consumers from maximally exercising choices, sharing in decision making, and being genuinely involved in oversight and helping to prevent malpractice.

25.1:
The Harvard Malpractice Study demonstrated that one in 25 hospitalized patients suffered a disabling iatrogenic injury, one quarter of these as a result of negligence.

25.2:
Reconciling consumers' legitimate demands to improve this performance with the need to protect confidentiality, the need to nurture candid professional introspection, and the current inadequacy of outcomes data for judging quality[55] poses difficult challenges.
25.3:
This requires trust and cooperation.
25.4:
Although we believe that a no-fault approach to malpractice is most consistent with the logic of CQI (which seeks prevention over blame), and universal coverage (which would already provide lifetime benefits for iatrogenic injuries, thus obviating the need to sue for such benefits), additional research is needed on questions of deterrence and effectiveness.

26.1:
Just as the concept of informed consent was once foreign, today's physicians are unaccustomed to thinking constructively about creating a health sphere in which difficult issues and alternatives are openly discussed.
26.2:
Gathering data about care practices and turning those data into information to be shared with peers and the public must become a key ethical duty.[46,56,57]
26.3:
New vistas for more public yet scientific and collegial oversight include designing and evaluating practice guidelines[58]; evaluation of patient satisfaction, complaint, and outcomes data, such as delayed or missed diagnoses[59]; ombudsman programs; alternative ways to adjudicate malpractice allegations[16]; interactive decision-making computer technology[60]; and more meaningful regulatory activities.[61-64]

27.1:
In the event of a medical mishap or untimely death, patients or relatives want an explanation and an opportunity to ask questions and receive full and honest answers, things we often fail to provide.[65]
27.2:
For centuries, the autopsy has fulfilled an important "convening" function for the profession to engage such questions and admit mistakes (unfortunately this valuable tool is increasingly neglected).[66]
27.3:
Practice databases may facilitate an analogous convening forum for bringing together the profession and the public to examine our record, thereby fulfilling our obligations for expanded public accountability.



28.1

7. Financial neutrality of medical decision making is essential to reconcile distorting influences of physician payment mechanisms with ubiquitous uncertainties in clinical medicine.

28.2:

Payment incentives may distort the quality of medical services.

28.3:

Fee-for-service favors excessive use of services, while capitation payment may encourage undertreatment.[54,67]

28.4:

To lessen this tendency for physician payment to distort treatment, we must strive to remove personal financial considerations from clinical decision making.

29.1:

Self-referral by physicians to medical facilities from which they profit is a particularly egregious example of a financial incentive distorting a physician's practice.

29.2:

Physician ownership of diagnostic imaging centers is associated with a referral rate four time that of their noninvesting physician colleagues.[68]

29.3:

Similarly deplorable are managed care arrangements that directly tie physicians' incomes to withholding referrals for diagnostic tests, specialty consultation, or hospitalization.

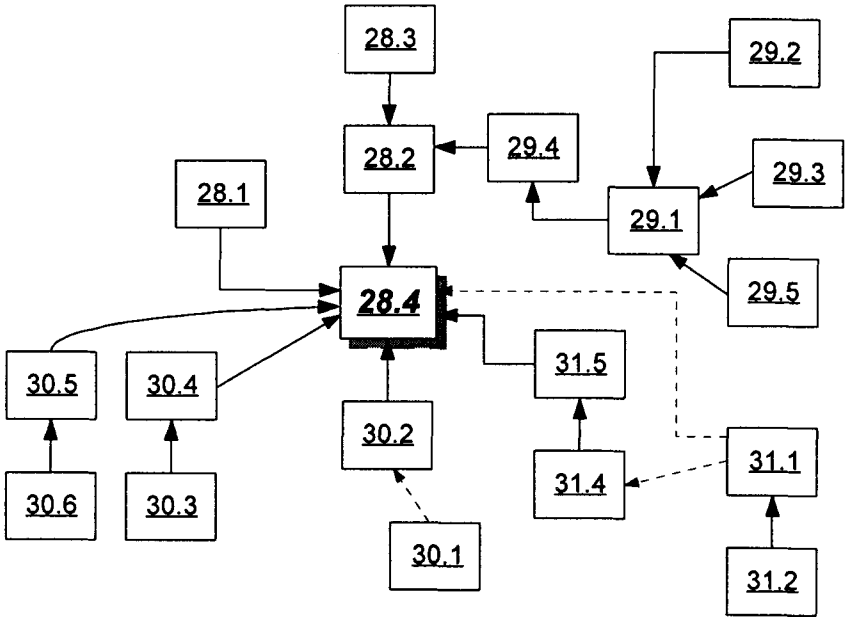
29.4:

These arrangements create an unacceptable conflict between a patient's welfare and a physician's financial interest.

29.5:

Even not-for-profit physician networks, portrayed by Clinton plan advocates as alternatives to insurance company or managed care inducements,[69] perpetuate this conflict of interest when they make providers assume "financial risk" for their patients.

30.1:
Physicians do need to make more cost-conscious and more cost-efficient decisions.
30.2:
However, we reject approaches that expect improved decision making to derive from tinkering with physician rewards.
30.3:
The problem is not insufficient motivation; it is the uncertainty which, as many have noted, is ubiquitous in medicine.[70]
30.4:
Financial incentives to manipulate physicians to do more or less conceal rather than address our clinical knowledge deficits.
30.5:
Physicians respond best to efforts, based on their intrinsic values, that motivate and involve them directly in improving patient care.
30.6:
Even when forced to choose between maximizing patient outcomes over their own financial gain, physicians typically choose to improve care.[71]
31.1:
We recognize that financial neutrality is an ideal.
31.2:
No payment mechanism completely removes the influence of payment on treatment.
31.3:
For example, while payment by salary separates day-to-day clinical decisions from financial considerations, it can encourage undertreatment or the avoidance of more complex patients who require expensive care.
31.4:
The current British approach, capitation supplemented with added fees for preventive services and complex cases illustrates one possible alternative.[72]
31.5:
Such arrangements at least channel incentives toward mutually agreed on positive objectives rather than creating conflicts and a lack of trust that poison provider-patient relationships.



32.1:
8. Emphasis should shift from micromanagement of providers' practices to macroallocation decisions.
32.2:
Public control over expenditures can improve quality by promoting regionalization, coordination, and prevention.
32.3:
The uncontrolled proliferation and duplication of expensive technology in our present system, considered by some the sine qua non of U.S. high-quality care, both adds to cost and detracts from quality.

33.1:
For example, because we have too many mammography machines, each is underutilized.
33.2:
This doubles the cost of each test.
33.3:
As a result, many women cannot afford the screening.
33.4:
Thus, because we have too many mammography machines, we have too little breast cancer screening.[73]

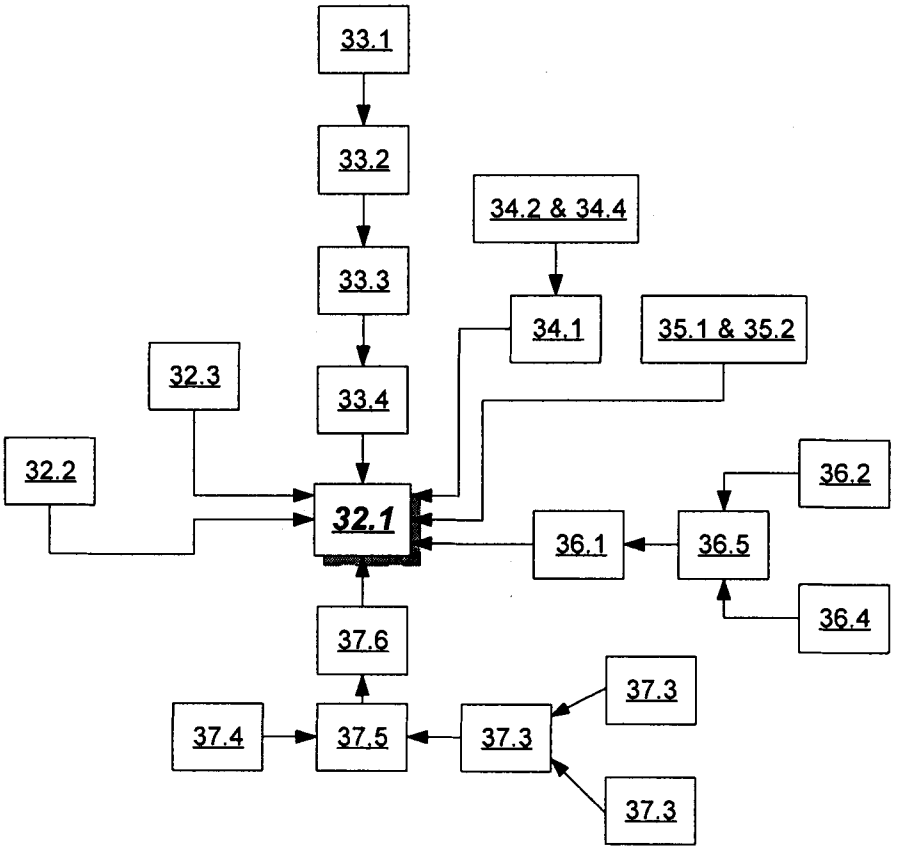
34.1:
For technically complex procedures, an inverse relationship between volume and mortality rates has generally been observed.[74]
34.2:
Yet, in the RAND appropriateness study, one fourth of the surgeons performingcarotid endarterectomies did only one such procedure per year (on Medicare patients).
34.3:
Three of four surgeons performed fewer than 10 endarterectomies—the average annual number performed by these surgeons was 3.4, a number most would consider too few to maintain proficiency.[75]

35.1:
Hospitals compete for patients by establishing competing specialized services rather than cooperating to establish one high-quality unit.
35.2:
Two decades of "regional planning" requiring certification for more costly capital expenditures have shown that, absent more direct financial control of capital allocations, such regulatory efforts have not succeeded.[76]

36.1:
Reorientation toward macroallocation broadens quality horizons in many ways.
36.2:
Establishing "fences" that prospectively define available resources means that less energy and money are wasted micromanaging each decision, and more energy is directed toward overall quality.[77]
36.3:
A child scolded to clean his plate because there are starving people in Africa may reasonably question the logic.

36.4:
Refusing intensive care treatment to an elderly patient because the resources could be better used for prenatal care is similarly hard to justify if we lack a structure to redirect the resources.[78]
36.5:
Global budgets allow managerial energies to be directed away from maximizing revenue, improving market share and expansion, toward improving quality.

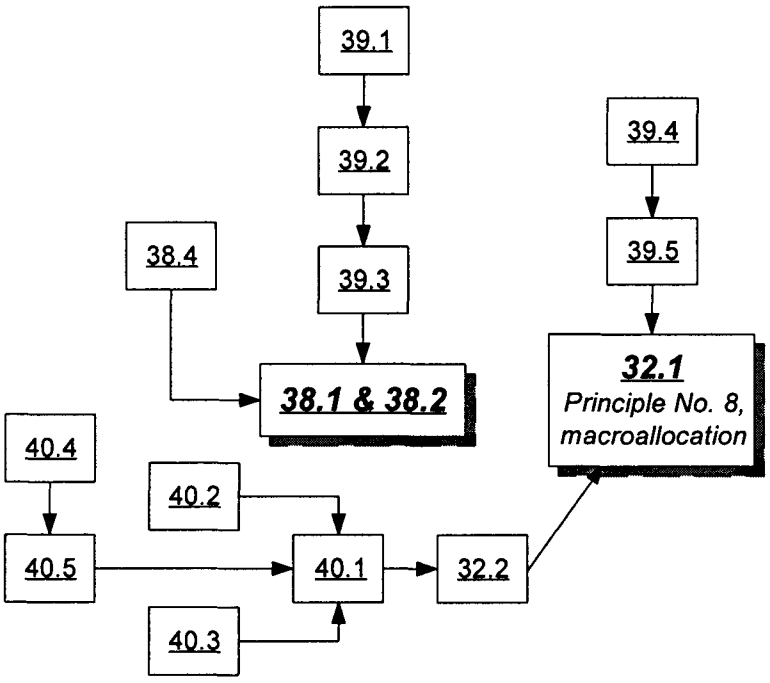
37.1:
Competition gurus rely on report cards to allow marketplace choices to drive competition toward better quality.
37.2:
They overestimate the precision of measurements at the level of the individual provider or health plan (*New York Times*. March 31, 1994: A1, A11)[79] as well as the higher "leverage" potential of coordinated system improvement.
37.3:
Because existing measures lack precision, cost may end up being the only "objective" measure.
37.4:
Berwick[80] has argued that quality needs to be induced rather than selected.
37.5:
Measuring performance ought to be aimed more at improving quality than at lubricating competition.
37.6:
Such improvement requires leadership committed to improving each component of the system as well as coordinating its various elements.



38.1:
9. Quality requires prevention.
38.2:
Prevention means looking beyond medical treatment of sick individuals to community-based public health efforts to prevent disease, improve functioning, and reduce health disparities.
38.3:
These simple goals, articulated in *Health People 2000,*[81] remain elusive.
38.4:
Nine preventable diseases are responsible for more than half of the deaths in the United States, yet less than 3% of health care spending is directed toward prevention.[82]

39.1:
Private health insurance attaches funding only to individual patients and thus separates the funding role and control from that of representing broader societal interests.[83]
39.2:
Insurance companies discovered risk factors, such as hypertension,[84] yet they used this insight primarily to exclude high risk individuals.
39.3:
This fragmenting of the community places both sick people and the social causes of disease outside the boundaries of medical care.
39.4:
Although rhetorically "prevention is cheaper than cure," many preventive measures probably increase costs.[85]
39.5:
This, combined with high patient turnover rates and short-term financial orientation, gives private insurors little incentive to invest in prevention.

40.1:
Health care financing should facilitate problem solving at the community level.
40.2:
Community-based approaches to health promotion rest on the premise that enduring changes result from community-wide changes in attitudes and behaviors as well as ensuring a healthy environment.[86,87]
40.3:
Stores that refuse to sell tobacco to minors and promote low-fat foods, schools that teach avoidance of human immunodeficiency virus infection, and a health department that can guarantee clean air and water have a more vital role in ensuring health than does private health insurance.
40.4:
According to Enthoven,[88] the originator of managed competition, its "goal is to divide providers in each community into competing economic units."
40.5:
Capitation payments to competing providers, in theory designed to motivate prevention, thus fracture the community and make community-based interventions more difficult because no provider has a population-based purview.



41.1
10. Affordability is a quality issue.
41.2:
Effective cost control is needed to ensure the availability of quality health care both to individuals and the nation.
41.3:
Good quality care should not mean expensive care; if it does it will not be available to most citizens.
41.4:
Flawed cost control reduces quality in many ways.
41.5:
It diverts resources from legitimate health needs, increases iatrogenic risks, and leads to financial barriers to care.
41.6:
These harmful impacts derive both from failure to contain costs and "side effects" of ill-conceived cost control measures.

42.1:
Despite multiple cost-control measures during the past two decades, costs continue to escalate.
42.2:
These measures have failed to slow growth of administrative costs, improve efficiency, curb ineffective or marginally effective services, or rein in excessive managerial or professional salaries or profits.[89,90]
42.3:
Moreover, many cost control initiatives have encouraged providers to discriminate against less profitable patients and increase their focus on fiscal rather than clinical goals.

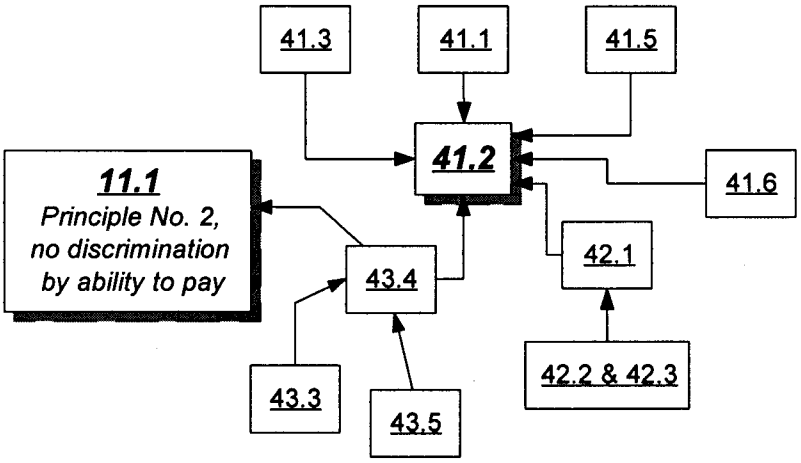
43.1:
The most prevalent approach to containing costs has been patient "cost sharing."
43.2:

Financial barriers have serious quality-impairing potential unless they are adjusted to patients' need for care and ability to pay.[91,92]

43.3:
It is impossible to erect a barrier high enough to discourage unnecessary care, low enough that needed care is not deterred, and simultaneously adjusted to a patient's discretionary income.

43.4:
Donabedian[91] argues that "even if such adjustments were made, financial barriers would remain too blunt an instrument for assuring a precise calibration of care to need."

43.5:
The RAND Health Insurance experiment confirmed this, finding that "changing economic incentives can alter the amount of care consumed, but implementing such measures appears to increase or decrease proportionately both appropriate and inappropriate use."[46]



CONCLUSION

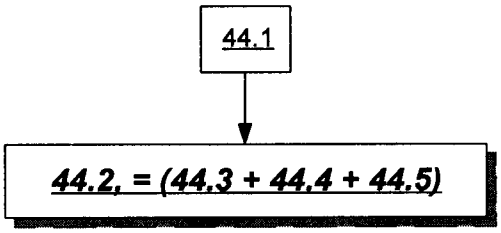
44.1:
Private insurors have regularly sought cheaper care, and to avoid paying beneficiaries' bills, but have rarely advocated better quality care for patients.[93]

44.2:
Health reformers in the United States should heed lessons learned in other industries.

44.3:
An obsession with cutting costs rather than with quality leads to both suboptimal care and higher costs.

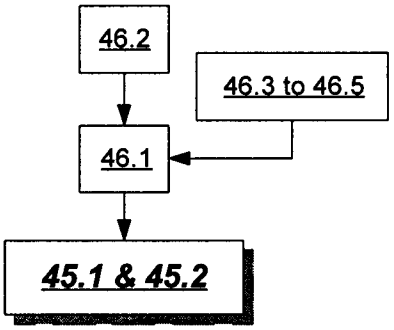
44.4:
Systems based on trust and common purpose achieve far more than those based on barriers and competition.

44.5:
In addition, solutions that tamper with a system, increasing complexity, are inferior to those that simplify the way a job is done.[52]



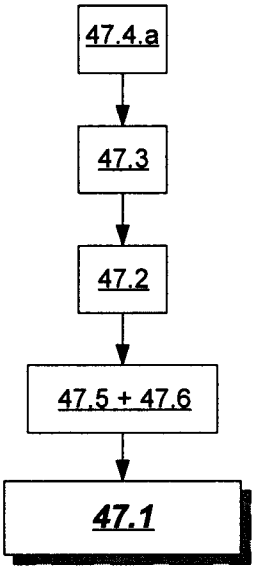
45.1:
Health-financing reform provides a pivotal opportunity to improve the quality of health care.
45.2:
We believe that a single payer national health program provides the most effective framework for implementing the quality-enhancing principles discussed above.

46.1:
A managed competition strategy, such as that proposed by the Clinton administration and debated in Congress, while designed to provide universal access, has not demonstrated an ability to contain cost and creates a complex structure with separate and unequal mutlitiered care.
46.2:
Eschewing the easily enforceable budgetary constraints of the single-payer approach necessitates reliance on potentially damaging financial incentives, wasteful micromanagement, and complicated budgetary regulation to minimize spending.
46.3:
Accountability, achievable only if patients are maximally empowered and involved, is structurally nurtured by an open and publicly controlled funding process and impeded under managed competition by multiple intermediaries between providers and patients.
46.4:
Effective implementation of computers in clinical medicine would be retarded by pecuniary interests favoring proprietary data and incompatible software formats and enhanced by public development, ownership, and standards.
46.5:
Global budgeting facilitates directing national resources based on the needs derived from these epidemiologic data, whereas competition ensures that resource allocation will depend on profitability.

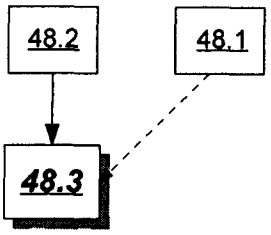


47.1:
No amount of regulation and oversight can breathe quality into a system that is not based on caring professionals working for patients.[26]

47.2:
There is little empirical evidence that report cards and regulatory constraints can reliably separate "good" from "bad" care.
47.3:
The technical capabilities of such measures are too imprecise, and incentives for gaming are too great (*New York Times*. March 31, 1994:A1, A11).[56,79,94]
47.4:
[.a] Such measures encourage mindless efforts to meet concrete, but in many cases tangential, criteria while emphasizing sanctions and policing, [.b] which run counter the CQI principles that empower workers think innovatively about processes.
47.5:
Regulation cannot revitalize a system controlled by financial institutions driven by fiscal incentives both efficiency and fraud, quality care as well as neglect of patients' problems.
47.6:
More regulatory and administrative overhead does mean less time and resources for patient care.



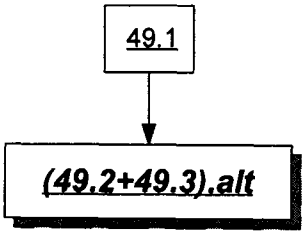
48.1:
A single-payer system is not a panacea for resolving these problems.
48.2:
What it does offer is a framework for collectively engaging these issues in a fair, cohesive, and effective fashion.
48.3:
The 10 principles outlined above, while neither a detailed blueprint of how a U.S. single-payer system would work nor a point-by-point critique of alternate reform proposals, suggest that important opportunities to improve quality would be compromised were the United States to settle for a managed competition approach.



49.1:
Rather than being a code word for the status quo, quality must become a pivotal guide for change.
49.2:
A unified system emphasizing cooperation, democratic accountability, and explicit planning is preferable to a fragmented approach with accountability abdicated to success or failure in the market and planning forsaken in favor of resource allocation based on profitability.
49.3:
Only this preferred approach to system redesign can lead us to a qualitatively better system, one that instills a sense of ownership and pride in its patients and providers.

– Alternative wording that combines 49.2 and 49.3 for clarity:

(49.2+49.3).alt:
Only a unified health care system re-design approach emphasizing cooperation, democratic accountability, and explicit planning can lead us to a qualitatively better system, one that instills a sense of ownership and pride in its patients and providers, one preferable to both the staus quo and all of the proposed alternative reforms.



Argument evaluation section begins next page.

1.1:
Many misconstrue U.S. health system reform options by presuming that "trade-offs" are needed to counterbalance the competing goals of increasing access, containing costs, and preserving quality. [1,2]

Evaluation: This is in fact a widely accepted view. Most consumers uncritically accept the idea that better quality costs more, the ostensible obviousness of which owes to a normally hazy notion of what is meant by "quality."

1.2:
Standing as an apparent paradox to this zero-sum equation are countries such as Canada that ensure access to all at a cost 40% per capita less, with satisfaction and outcomes as good as or better than those in the United States.[3,4]

Evaluation: The Canadian system does in fact deliver care to all at a much lower per capita cost. There is, however, credible evidence of significantly increasing financial strains, and some deterioration in the satisfaction of Canadian health care beneficiaries. Also, Canadian taxes are quite high relative to ours.

1.3:
(.a) While the efficiencies of a single-payer universal program are widely acknowledged to facilitate simultaneous cost control and universal access, **(.b)** lingering concerns about quality have blunted support for this approach.

Evaluation: Indeed, and part of the concern has to do with the mixed reviews accorded single-payer systems such as the Canadian and British, particularly the much maligned British Public Health Service.

Sub-argument assessment: The argument for conclusion 1.1 is only partially true. It also the case that the meager support for a single payer system has to do with the public's dissatisfaction with the performance of many publicly administered U.S. agencies. People have a legitimate concern that a single payer system will be yet another expensive and unresponsive bureaucracy. The premise that such systems are widely viewed as more significantly more efficient is open to dispute.

■

2.1:
Quality is of paramount importance to Americans.

Evaluation: While true to an extent, it is a simplistic assertion. Survey data repeatedly reveal that healthy people rank cost and access highest, with "quality" concerns far down the list. On the other hand, once a person is injured or severly ill, access and quality (meaning a good clinical outcome) are the priorities—and cost be damned.

2.2:
Opponents of reform appeal to fears of diminished quality, waiting lists, rationing, and "government control."[5]

Evaluation: As we have seen ad nauseum this past year, this assertion is absolutely true. Recall, for example, the oft-repeated remark of reform opponent Texas Senator Phil Gramm, that he would "not allow the Clintons to tear down the finest health care system in the world and re-make it in the image of the Post Office."

2.3:
Missing from more narrow discussions of the accuracy of such charges is a broader exploration of the quality implications of a universal health care program.

Evaluation: Again, true. The reform debate has focused principally on coverage and cost issues.

2.4:
Conversely, advocates of national health insurance have failed to emphasize quality issues as key criteria for reform,[6] often assuming that we have "the best medical services in the world."[7]

Evaluation: In terms of high-technology medical heroics, it is true that the U.S. medical system performs wonders. It is also true there are repeated and frequently egregious blunders and other outrages. Not all malpractice ligitation is frivolous, by any means. There are boundless opportunities for improvement.

2.5:
They portray reform primarily as extending the benefits of private insurance to those currently uninsured, with safeguards added to preserve quality.

Evaluation: Yes, this has been the principal focus of the major reform debates.

Sub-argument assessment: I agree with this argument, with the exception of premise 2.1. Again, a major concern of most citizens has to to with cost and bureaucracy. Whereas people are aware of concerned about the quality of goods and services they routinely purchase, medical services are something we don't even like to think about—until we need them badly.

■

3.1:
We disagree with both views.
3.2:
It is unthinkable to label our current system as "highest quality" given its frequent failure to provide such basic services as immunizations or prenatal, primary, or preventive care.

Evaluation: This is where the authors begin to expand the definition of health care "quality," a term conventionally construed as meaning satisfactory clinical outcomes for those who have access to the system. So, yes, this is a valid criticism if we accept that access for all is a quality criterion. Many people, however, dispute the notion, declining to accept that access to health care by entitlement is ethically proper, arguing that, if health care is my "right," then someone else has an "obligation" to provide me with it, at a cost I can "afford."

3.3:
Moreover, there is growing concern about quality problems with the care that is provided.

Evaluation: It is true that concerns are expressed, both within the industry and by its customer, as they have long been. It is not clear, however, that the concerns are "growing" except with respect to perceptions of runaway costs.

3.4:
Quality problems in the current system include denial of care, discrimination,[8] disparities, geographical maldistribution,[9] lack of continuity, lack of primary care,[10] inadequate or lack of prenatal care,[11] failure to provide beneficial prevention,[12] substandard/incompetent providers, [13] declining patient satisfaction and

impersonal care,[14,15] iatrogenesis (negligent adverse events),[16] diagnostic errors,[17] unnecessary procedures/surgery,[18] suboptimal medication prescribing/usage,[19] and neglect of quality-of-life/psychosocial issues.[20]

Evaluation: One would have to closely inspect the references before accepting some of these assertions. While I would agree with many of the assertions in 3.4, given that I work in health care oversight and work on such issues every day, I am not persuaded, for example, that "patient satisfaction" is declining across the board, nor would I accept that providers are solely accountable for some of the adversities cited here. Some issues such as continuity of care and patient compliance are often beyond the control of the health care provider.

3.5:
Our "highest-quality" complacency is especially challenged by insights from two seeming disparate sources: (1) epidemiologic research based on financial claims databases and (2) industrial quality improvement concepts pioneered in Japan.

3.6:
These two sources converge around the concept of "variation," illuminating widespread differences in clinical practice, further challenging the cost-access-quality tradeoff assumption.

Evaluation: Yes, indeed, this is true. The agency I work for is involved in addressing these very issues. It is incontrovertible that there are often dramatic variations in clinical practice and outcomes that have no readily apparent scientific rationale.

3.7:
Data and insights from these two new paradigms demonstrate that better care will actually cost less once improvements are made in care processes and clinical decision making.[21,22]

Evaluation: Again, quite true. It is commonly believed that financial imperatives in medicine are shifting from the incentive to "overtreat" under the old fee-for-service system, to an imperative to "undertreat" in a capitated environment where every additional service comes out of the provider's profit. But there is increasingly compelling evidence that focusing on the highest quality clinical practice is significantly less expensive overall.

Sub-argument assessment: Conclusion 3.7 is compelling. But resources are finite, and tough decisions will continue to be needed regarding what we as a society wish to pay for. Conclusion 3.2 has strong support, but requires a substantial value judgement as to the propriety of making basic services available by entitlement. That the cause of community health will be enhanced is very likely. That it will thereby save money is in dispute by many, even health professionals.

■

4.1:
The health system must work better to extend access and to control costs.

Evaluation: Everyone would agree. The debate rages over how best to accomplish the goal.

4.2:
In this article, we argue that a single-payer national health program provides a better framework for improving quality.

4.3:
First, we briefly review requirements for improving quality.

4.4:
Then, we propose 10 principles that should be integral to reform strategies to augment quality.
4.5:
We contrast our approach with the current managed competition[23] strategy, showing how a single-payer system is more likely to facilitate these 10 interrelated quality features.

Sub-argument assessment: Argument 4.x really just sets the stage for the detailed evidence and reasoning to follow. Premise 4.1 is open to dispute; while we can agree that costs in *any* business should be controlled, one could argue that it is not necessarily the responsibility of the health system to seek to "extend access," a function perhaps more appropriate for other sectors of society.

■

WHAT IS QUALITY? HOW CAN IT BE MEASURED?

5.1:
High-quality care should result in improved health for individuals and the entire community.

> **Evaluation:** No one would dispute this as a social ideal, and a laudable goal, perhaps with the qualifier "to the extent practicable" with respect to "the entire community" part of the statement.

5.2:
It depends on knowledgeable, caring providers who have a thorough understanding of preventive, diagnostic, and therapeutic strategies and the link between their application and improved health outcomes.

> **Evaluation:** True.

5.3:
Such strategies need to be applied with the highest technical skill and carried out in a humane, culturally sensitive, and coordinated manner,

> **Evaluation:** True, except that I wish people would quit overusing the word "strategies" where they often really mean "tactics" or "procedures."

5.4:
Quality will suffer when any of these components is lacking.

> **Evaluation:** True.

Sub-argument assessment: Argument 5 is valid, as an ideal. It assumes including improved "community health" as a criterion for assessing quality of care. Some people, though, think this goes too far.

■

6.1:
These is no single standard measurement of health care quality; its assessment requires multiple perspectives.

> **Evaluation:** Here again we see the expansion of the definition of "quality." Should it mean more than simply satisfactory clinical outcomes?

6.2:
The care provided to the population as a whole as well as to individual patients should be evaluated because critical quality issues may affect individuals who do not have access to medical services.

Evaluation: Critical personal health quality issues? If so, true.

6.3:
Viewpoints of providers, patients, family members, and the community must be incorporated.

Evaluation: True if you accept that health care is something more than just another for-profit enterprise. Some do not accept such a characterization.

6.4:
Evaluated services should not be limited to medical care but should also include related services, such as nursing services, social services, and community education.

Evaluation: True, if, again, you accept that health care is something more than just another for-profit enterprise.

6.5:
To judge quality, we need a lengthened time frame that allows not only for examination of longer-term impacts but also for changes over time in what is considered good care.

Evaluation: True.

6.6:
Finally, quality should be judged in the context of costs, because when equally good care is provided at a lower cost, more resources are made available for other services.

Evaluation: True.

Sub-argument assessment: If you accept that health care should not be a private, for-profit enterprise, all of the premises in 6 work. Many political conservatives will strenuously object, particularly to 6.2, 6.3, and 6.4. The conclusion 6.1 may be reached, from a strictly clinical perspective, without 6.2 - 6.4.

■

7.1:
Although consensus has emerged around many of these precepts,[24,25] there is disappointment over the extent to which their fragmented application has actually improved care.[26,27]

Evaluation: True, it is the subject of much debate within the industry.

7.2:
This meagerness of demonstrated benefit is especially worrisome given providers' frustration with the time and administrative burdens imposed by current oversight measures.

Evaluation: True, many providers do in fact chafe under what they see as mindless regulation that adds nothing to the quality of care.

7.3:
Promising efforts to operationalize these precepts on a larger scale (i.e., Agency for Health Care Policy Research, the Joint Commission on Accreditation of Healthcare Organization's Agenda for Change, and Medicare's Quality Improvement Initiative-HCQII)[28] will continue to have limited success if not linked to more fundamental changes in health care finance and delivery.

Evaluation: True. The jury is out on these programs. I work under the Medicare HCQII program, and the effectiveness of our program is not universally accepted, even by many of our own colleagues.

7.4:
This will require health system reform based on the application of quality assurance tools and insights, guided by the principles outlined below.

Evaluation: I am persuaded that "the application of quality assurance tools and insights" indeed will be the most effective means of system improvement.

Sub-argument assessment: There is indeed a strong case for this argument overall. Argument 7 is valid, but "devil is in the details," as we shall see.

■

TEN PRINCIPLES FOR IMPROVED QUALITY

8.1:
1. (a) There is a profound and inseparable relationship between access and quality: (b) universal insurance coverage is a prerequisite for quality care.

Evaluation: A hotly contested notion. Back to the "entitlement" debate.

8.2:
(a) Because quality must be population-based, (b) traditional definitions of quality should be broadened to include the gravest of quality deficits—denial of care.[28]

Evaluation: This is true, though many would object strenuously. But, given that, as a society we have by now codified a legal right to acute care in life-threatening circumstances, many of those denied care will eventually find themselves in such straits, where their care will be much more expensive, and society *will* pay those extra costs.

8.3:
The most important prerequisite for access is health insurance.

Evaluation: True. Medical insurance serves a vital public and private good, given the unpredictability of continued individual health.

8.4:
To delay universal coverage for years, as projected in the Clinton plan and various congressional health proposals, means the continuation of compromised quality for millions of people.

Evaluation: True.

9.1:
Growing evidence from large observational studies underscores this strong relationship between quality and access/insurance status:

Evaluation: The validity of this hinges on the credibility of the data offered in support of 9.1.

9.1.1:
The hospitalized uninsured are 2.3 times more likely to suffer adverse iatrogenic events.[29]

9.1.2:

The loss of Medicaid coverage has been associated with a 10-point increase in diastolic blood pressure and a 15% increase in the hemoglobin A_{1c} level in diabetic patients, increasing the odds of dying within 6 months by 40%.[30]

9.1.3:
The uninsured poor are twice as likely as those with private insurance to delay hospital care; among those delaying care, hospital stays are longer and death rates are higher.[31]

9.1.5:
Being uninsured was associated with twice the 15-year mortality (18.4% vs 9.6%); even after adjusting for major risk factors, mortality remained 25% higher.[32]

9.1.6:
Lack of health insurance is associated with failure to receive preventive services, including blood pressure monitoring, Papanicolaou tests, breast examinations, and glaucoma screening.[33]

Evaluation: I would accept the foregoing as good evidence in support of the claim of 9.1, with the reservation that correlational studies often indicate, but do not conclusively establish, causal relationships. There could plausibly be other, possibly equally pertinent factors involved in the elevated risks cited. *Everything* is harder on the poor.

10.1:
This profound connection between quality and access extends far beyond simply underserving the uninsured.

Evaluation: OK. See below.

10.2:
Access problems threaten quality for those with insurance who can encounter delays and overcrowding in emergency departments overflowing with patients lacking primary care.[34]

Evaluation: This is emphatically true.

10.3:
For the insured, limitations on benefits, including financial barriers (such as co-payments, restrictions in coverage, and rationing via administrative obstacles), increasingly obstruct care.[35]

Evaluation: My wife just having been through (well-insured) arthroscopic surgery, I attest that this is true. It's sometimes referred to as "rationing by administrative hassle."

10.4:
More important, quality is distorted when ability and willingness to pay become the criteria for determining which services are provided.

Evaluation: See 10.5.

10.5:
Marginally effective or even harmful treatments for the well-insured affluent take priority over more needed and appropriate services.[36]

Evaluation: Often true, but to what extent is not clear.

Sub-argument assessment: Overall, a strong argument, with the caveat about implying causality from correlational data. While I am persuaded that universal coverage can in fact enhance the quality of care, it does not, however necessarily follow. Moreover, I see no good

data to the effect that dubious therapies such as vanity treatments for the wealthy constitute a visible proportion of total health care spending.

■

11.1:
2. The best guarantor of universal high-quality care is a unified system that does not treat patients differently on the basis of employment, financial status, or source of payment.

Evaluation: This is a *major* political bone of contention. Conservatives detest such a notion, decrying the assertion that they should be prohibited from purchasing the "finest care" they can afford, and also that those who live responsibly should benefit therefrom.

11.2:
This principle embodies Eddy's health care "golden rule": If a service is necessary for oneself, it is necessary for others.[37]

Evaluation: This is a central ethical issue, one that draws fire similar to that of 11.1.

11.3:
We reject the notion that different people are entitled to a different quality of care.

Evaluation: Again, many people vehemently object to what they would characterize as "discredited socialist dogma."

12.1:
The quality-impairing consequences of separate classes of insurance are illustrated by Medicaid, whose recipients, though "insured," are often refused care or provided substandard treatment.[38]

Evaluation: The generally poorer quality of health care accorded Medicaid recipients is beyond dispute.

12.2:
For many medical services, access for Medicaid patients is little better than for the uninsured (D.U. Himmelstein and S. Woolhandler, unpublished tabulations from the 1987 National Medical Expenditures Survey).

Evaluation: True.

12.3:
Similarly, universally available lowest-tier coverage, such as that proposed under managed competition, with more or better services only for those able to afford to upgrade their benefits, violates this principle and would perpetuate inequalities in health care.

Evaluation: Yes it would perpetuate inequalities, for which reform opponents would have a ready "so what? This is the land of opportunity" reply.

13.1:
The equality principle is a prerequisite to grapple meaningfully with ways to control marginally effective expensive interventions.

Evaluation: Possibly so, but it may not be the only way.

13.2:
Otherwise, limits based on ability to pay are, by definition, discrimination against the poor.[39]

Evaluation: The phrase "discrimination against the poor" in this context has a polemic tone to it that many would find offensive. The statement is objectively true. *Any* service denied on the basis of inability to pay discriminates against those without the funds.

14.1:
Under a multitiered system patients and providers internalize an "everyone for himself or herself" ethic, eroding incentives for improving the system overall.[40]

Evaluation: True.

14.2:
A cohesive system based on fairness and equality could harness each citizen's desire for quality care to drive system quality upward.

Evaluation: It could. But it could also generate a feeling of rude and demanding "entitlement" that might engender bitter reaction that detracts from quality, given that other segments of U.S. society ar e quite likely to remain meritocratic and otherwise status-driven.

14.3:
It would promote mechanisms for individual complaints to be linked to system-wide improvement, rather than dissipated as special privileges.

Evaluation: It "might" or "could," not automatically "would."

14.4:
It would ensure that the quality of the basic plan is high enough to be acceptable to all citizens.

Evaluation: Maybe. It would be a major feat to achieve buy-in from those who currently enjoy excellent benefit programs.

14.5:
Proposals that allow individual or corporate "opting out" of publicly defined benefits packages erode this quality-enhancing covenant.

Evaluation: True. A significant problem with the British and Canadian systems, where the wealthy buy their way out to superior services.

14.6:
Hence, a single program not only minimizes discrimination against the vulnerable but also promotes improvement overall.

Evaluation: It *could*, but it does not deductively follow that such would promote improvement overall. It would, however, likely mean an improvement in overall care for the poor.

Sub-argument assessment: Conclusion 11.1 is highly speculative; while phrased in present-tense grammar, it is conjectural, and the support for the supposition hinges on acceptance of the inclusion of yet contested social and political values in defining the quality of health care.

■

15.1:
3. Continuity of primary care is needed to overcome fragmentation and overspecialization among health care practitioners and institutions.

Evaluation: True.

15.2:
Patients need care coordinated by the primary care provider of their choice.

Evaluation: True. The importance of a comfortable doctor-patient cannot be overestimated.

15.3:
Whether evaluating a confused elderly patient or discontinuing aggressive care to a patient with emphysema, a continuing physician-patient relationship is the essential foundation that allows physicians to practice conservative, sensitive, appropriate, cost-effective medicine.

Evaluation: True.

15.4:
Competitive models that encourage patients to switch among competing plans discourage ongoing relationships.[41]

Evaluation: True.

15.5:
Competition also blunts incentives for prevention because the resulting savings are likely to accrue long after the patient has switched to a rival plan.

Evaluation: True, unless the provider's quality is so routinely good that patients become fiercely loyal.

16.1:
As practitioners, we do quality work when patients can trust that we will be available with the time, independent judgment, and familiarity with their problems to give them skillful personal attention.

Evaluation: True.

16.2:
Cost-containment efforts designed to limit utilization have counterproductively undermined this primary caring role.

Evaluation: True.

16.3:
Erecting financial barriers to discourage contact, penalizing the primary practitioner for ordering tests and consultations, and intrusive utilization review measures have contributed to growing dissatisfaction with primary care practice.[42,43]

Evaluation: True, a major concern with the HMO model.

Sub-argument assessment: Argument 15 - 16 is moderately strong, though it is not clear that "continuity of primary care" will of itself have much to do with reducing overspecialization. Also, I would disagree that competition is necessarily inimical to a focus on preventive care.

■

17.1:
4. A standardized confidential electronic medical record and resulting database are key to supporting clinical practice and creating the information infrastructure needed to improve care overall.

Evaluation: True, but fraught with imposing legal and technical difficulty.

17.2:
Information technology should allow us to zoom in to focus on the microdetails of why a particular clinical decision was made, as well as give a macro-overview disease patterns in populations.

Evaluation: True.

17.3:
Its memory should permit panning backward and forward in time, seeing our own patients' past histories, as well as aggregating data to project disease natural history and response to interventions.

Evaluation: True.

18.1:
Unfortunately, implementation of medical computing has been driven by insurance/billing imperatives, often ignoring information needs for improved patient care.

Evaluation: True.

18.2:
The Institute of Medicine Committee on Improving the Medical Record has documented the ways that paper-based medical records and computerized laboratory and claims data fail to coalesce into integrated patient care records, capable not only of storing patient data but also of improving the quality of care.[44]

Evaluation: True.

18.3:
Consider routine, yet currently difficult clinical decisions, such as whether a patient's wound requires a tetanus shot, or a positive syphilis serology result requires treatment, or a decreased hematocrit requires further workup.

Evaluation: And such data are routinely unavailable at decision-making time. It is a chronic problem.

18.4:
Computer technology should permit us to track over time across multiple sites and support higher quality clinical decision making.

Evaluation: True, but again, laden with difficult non-clinical implications.

18.5:
Its potential for real-time reminders, prescribing, and bibliographic assistance is vast but unrealized.[44,45]

Evaluation: True.

19.1:
Realizing the computer's quality support potential hinges on strong guarantees of personal data confidentiality,[44] uniformity and integrity of data systems, availability of aggregate data in the public domain,[46] and minimization of costs, especially for software development and data acquisition.

Evaluation: True. And a major proposed undertaking, especially given the pace of change in computing technology.

19.2:
Creating national standards for protection of patients' privacy is one of the most important issues that health system reform must address, yet prospects for federal leadership appear to be confused and uncertain.[47,48]

Evaluation: True. The nature of our legal system has a good bit to do with this.

19.3:
The United States lags behind other countries in developing a secure clinical information infrastructure because it lacks a unified approach.

Evaluation: True.

19.4:
No public entity has sufficient scope or authority to spearhead this project.[49]

Evaluation: True. Nor likely the expertise.

20.1:
Despite a lengthy section on information automation, the Clinton proposal perpetuates the primacy of financial data to the neglect of clinical information by calling for computerized billing but not computerized patient care records.[50]

Evaluation: True. Clinton's big concern has been with federal health care expenditures, which account for around half of total U.S. health costs and are growing rapidly, threatening the rest of the federal budget needs.

20.2:
Furthermore, managed competition compromises for advancing the public's health by fragmenting information among competing health plans and creates incentives for distortion (i.e., "diagnosis creep") that arise when data are linked to financial rewards.[51]

Evaluation: True. "Code gaming" is a fine art.

Sub-argument assessment: While a uniform health care computer system and database would be very useful, it would be a massive undertaking that would in all likelihood never work well as envisioned. The generational life cycle of computing equipment and software is estimated to be about 18 months (and decreasing). A single national medical computing development project might well be obsolete by the time it got out of beta testing. For example, the Health Care Financing Administration (HCFA), which oversees Medicare and Medicaid (and to whom my agency contracts) is currently two to three generations behind the commercial state of the art in computing technology. We find ourselves having to maintain "backward compatibility" to be able to interface with them electronically, and our agency is not nearly equipped at cutting-edge levels. The pace of change in digital technology is both blessing and curse.

■

21.1
5. Health care delivery must be guided by the precepts of continuous quality improvement (CQI).

Evaluation: I am persuaded that this is entirely so.

21.2:
Improved data combined with statistical thinking permit a more scientific practice of medicine.

Evaluation: True.

21.3:
Five ideas are basic to CQI:[22,52,53]
21.3.1:
Systems improvement: addressing underlying causes rather than inspecting for and micromanaging individual practice variations.

Evaluation: True.

21.3.2:
Teamwork and cooperation: shift from fear, individual blame, and competition toward cooperation to improve interactions within and between organizations.

Evaluation: True.

21.3.3:
Overriding commitment to quality: quality should be the foremost mission and central preoccupation of health system leaders and reform efforts; cost savings derive from this primary commitment to quality.

Evaluation: True.

21.3.4:
Improvement of processes: quality can be continually improved by study, innovation, and simplification of the numerous small steps involved in performing daily tasks, leading to an organizational atmosphere of experimentation and productive change.

Evaluation: True. CQI is nothing more than the application of the scientific method to process evaluation, and controlled process experimentation that leads eventually to material improvements that add net value.

21.3.5:
Empowerment of workers and customers: frontline workers must have the authority, resources, and statistical tools to conduct process improvements.

Evaluation: True. But "empowerment" is in danger of becoming a cliche.

21.3.5.1
Patients' voices must be amplified so that their needs can be better addressed as the central aim of health care.

Evaluation: True. This is truly fundamental. Quality means customer focus.

22.1:
Current widespread endorsement of CQI belies a continuing focus on external inspection, short-term financial gain as the measure of success, inefficient cost-control measures, and disruptions of physicians' relationships with patients and colleagues as employers and insurers seek the lowest price (*New York Times*, January 24, 1993:1).[22,41,43,54]

Evaluation: True. Many organizations do not buy in all the way to the complete cultural shift that is required. Then they play "see, I-told-you-so" when improvement results are less than dramatic.

22.2:
Under our current system, each insurer must protect its financial stake through these shortsighted measures that disrupt overall quality.

Evaluation: Seemingly true. It's still principally a for-profit industry, and for many, the short-term profits are quite nice indeed. But eventually there will be trouble.

22.3:
Well situated to exercise such undesirable options, insurers cannot risk the long-term commitments to patients and providers, plus loss of management prerogatives, inherent in the five elements of CQI.

Evaluation: They mostly assume this to be true.

23.1:
Improving individual providers' care can best be accomplished via supporting their ability to practice quality care coupled with pooled outcomes data and patient feedback.

Evaluation: True.

23.2:
This contrasts to the current punitive, exclusionary, and competitive approaches.

Evaluation: True.

23.3:
The thrust of CQI is to improve the norm of performance rather than to merely identify outliers.

Evaluation: True. And when the norm moves higher, the quality weaklings are all the more easily identified.

23.4:
Where individual competence and performance deficiencies do exist, they must be conscientiously and definitively resolved.

Evaluation: True.

23.5:
Continuous quality improvement creates a climate and provides tools to accomplish this more fairly and constructively.

Evaluation: Properly applied, it will.

Sub-argument assessment: The authors' characterization of CQI is essentially correct, with a couple of small mistakes. First, they posit that "five ideas are basic to CQI," and go on to list six (21.3.1 through 21.3.5.1). Secondly, 21.3.1 is technically incorrect; it should say "systems*focus*," meaning the ability to see the forest as well as the trees, i.e., the recognition that changes made to processes without regard to the larger system usually beget adverse unintended consequences. The second part of the statement actually belongs in 21.3.4.

The fundamental elements of CQI are better stated as:

1. Customer orientation.
2. Systems focus.
3. Organization-wide commitment to quality.
4. Emphasis on teamwork.
5. Empowerment of workers.
6. Prioritized and coordinated improvement of processes.

■

24.1:
6. New forums for enhanced public accountability are needed to improve clinical quality, and to address and prevent malpractice, and to engage practitioners in partnerships with their peers and patients to guide and evaluate care.

Evaluation: True. The ultimate hovering threat of malpractice litigation serves only to encourage suspicion and wasteful "defensive" medicine.

24.2:
Patients' and practitioners' mutual desire to redress and prevent suboptimal medical outcomes should make them natural allies.

Evaluation: True.

24.3:
Instead, we are witnessing growing antagonisms.

Evaluation: I don't necessarily agree with this. The antagonisms may be stable, or even perhaps declining in some places. What are some extensive concrete data to support this assertion?

24.4:
The narrow emphasis on antagonistic all-or-none approaches, such as lawsuits, or exiting one plan for another, constrains consumers from maximally exercising choices, sharing in decision making, and being genuinely involved in oversight and helping to prevent malpractice.

Evaluation: Again, not to deny a problem, I would just offer that this may be overstated..

25.1:
The Harvard Malpractice Study demonstrated that one in 25 hospitalized patients suffered a disabling iatrogenic injury, one quarter of these as a result of negligence.

Evaluation: Very likely true.

25.2:
Reconciling consumers' legitimate demands to improve this performance with the need to protect confidentiality, the need to nurture candid professional introspection, and the current inadequacy of outcomes data for judging quality[55] poses difficult challenges.

Evaluation: True. Yes indeed it does.

25.3:
This requires trust and cooperation.

Evaluation: Would an attorney say that?.

25.4:
Although we believe that a no-fault approach to malpractice is most consistent with the logic of CQI (which seeks prevention over blame), and universal coverage (which would already provide lifetime benefits for iatrogenic injuries, thus obviating the need to sue for such benefits), additional research is needed on questions of deterrence and effectiveness.

Evaluation: Quite true. And the research should extend to the legal system.

26.1:
Just as the concept of informed consent was once foreign, today's physicians are unaccustomed to thinking constructively about creating a health sphere in which difficult issues and alternatives are openly discussed.

Evaluation: This is changing. Younger physicians are much more willing to engage such candor to the extent possible.

26.2:
Gathering data about care practices and turning those data into information to be shared with peers and the public must become a key ethical duty.[46,56,57]

Evaluation: True. It's the only way to advance the science of medicine.

26.3:
New vistas for more public yet scientific and collegial oversight include designing and evaluating practice guidelines[58]; evaluation of patient satisfaction, complaint, and outcomes data, such as delayed or missed diagnoses[59]; ombudsman programs; alternative ways to adjudicate malpractice allegations[16]; interactive decision-making computer technology[60]; and more meaningful regulatory activities.[61-64]

Evaluation: True. And a very big set of tasks.

27.1:
In the event of a medical mishap or untimely death, patients or relatives want an explanation and an opportunity to ask questions and receive full and honest answers, things we often fail to provide.[65]

Evaluation: True.

27.2:
For centuries, the autopsy has fulfilled an important "convening" function for the profession to engage such questions and admit mistakes (unfortunately this valuable tool is increasingly neglected).[66]

Evaluation: True.

27.3:
Practice databases may facilitate an analogous convening forum for bringing together the profession and the public to examine our record, thereby fulfilling our obligations for expanded public accountability.

Evaluation: True, and the sooner the better.

Sub-argument assessment: While this argument makes a strong case for methods to improve accountability, the existing tort system looms as a major impediment. In this instance, a "systems focus" would have to include the legal system. There is, and will likely remain, significant opposition to the type of legal reforms that would facilitate changes in accountability systems in health care.

■

28.1

7. Financial neutrality of medical decision making is essential to reconcile distorting influences of physician payment mechanisms with ubiquitous uncertainties in clinical medicine.

Evaluation: True.

28.2:

Payment incentives may distort the quality of medical services.

Evaluation: True.

28.3:

Fee-for-service favors excessive use of services, while capitation payment may encourage undertreatment.[54,67]

Evaluation: True, but shortsighted.

28.4:

To lessen this tendency for physician payment to distort treatment, we must strive to remove personal financial considerations from clinical decision making.

Evaluation: It would help.

29.1:

Self-referral by physicians to medical facilities from which they profit is a particularly egregious example of a financial incentive distorting a physician's practice.

Evaluation: True.

29.2:

Physician ownership of diagnostic imaging centers is associated with a referral rate four time that of their noninvesting physician colleagues.[68]

Evaluation: I am certain this is true.

29.3:

Similarly deplorable are managed care arrangements that directly tie physicians' incomes to withholding referrals for diagnostic tests, specialty consultation, or hospitalization.

Evaluation: True. HMO's that are run for short-term profit often interfere with clinical judgement in the interst of short-term cost savings.

29.4:

These arrangements create an unacceptable conflict between a patient's welfare and a physician's financial interest.

Evaluation: Yes, they absolutely do.

29.5:

Even not-for-profit physician networks, portrayed by Clinton plan advocates as alternatives to insurance company or managed care inducements,[69] perpetuate this conflict of interest when they make providers assume "financial risk" for their patients.

Evaluation: True.

30.1:
Physicians do need to make more cost-conscious and more cost-efficient decisions.

Evaluation: True.

30.2:
However, we reject approaches that expect improved decision making to derive from tinkering with physician rewards.

Evaluation: I agree.

30.3:
The problem is not insufficient motivation; it is the uncertainty which, as many have noted, is ubiquitous in medicine.[70]

Evaluation: True.

30.4:
Financial incentives to manipulate physicians to do more or less conceal rather than address our clinical knowledge deficits.

Evaluation: True.

30.5:
Physicians respond best to efforts, based on their intrinsic values, that motivate and involve them directly in improving patient care.

Evaluation: Overwhelmingly true.

30.6:
Even when forced to choose between maximizing patient outcomes over their own financial gain, physicians typically choose to improve care.[71]

Evaluation: True. While there are some physicians that are businessmen first and foremost, the vast majority are highly skilled, ethical, and compassionate.

31.1:
We recognize that financial neutrality is an ideal.
31.2:
No payment mechanism completely removes the influence of payment on treatment.

Evaluation: True.

31.3:
For example, while payment by salary separates day-to-day clinical decisions from financial considerations, it can encourage undertreatment or the avoidance of more complex patients who require expensive care.

Evaluation: True, it can, typically in the for-profit captitated environment.

31.4:
The current British approach, capitation supplemented with added fees for preventive services and complex cases illustrates one possible alternative.[72]

Evaluation: Possibly true.

31.5:
Such arrangements at least channel incentives toward mutually agreed on positive objectives rather than creating conflicts and a lack of trust that poison provider-patient relationships.

Evaluation: True.

Sub-argument assessment: This argument is strong. Perverse financial incentives tend to work at cross-purposes with quality clinical decision-making. A single-payer system could better preserve providers' independent clinical judgement. However, independence of clinical judgement is not necessarily precluded in the managed care model, provided that management truly adopt and practice the philosophy and methods of CQI. Examples exist that such indeed works well (e.g., IHC, Intermountain Health Care in Utah).

■

32.1:
8. Emphasis should shift from micromanagement of providers' practices to macroallocation decisions.

Evaluation: True, but it does not automatically follow that a single national public program is the only way to attain the goals.

32.2:
Public control over expenditures can improve quality by promoting regionalization, coordination, and prevention.

Evaluation: Yes, possibly, but public control could also lead to a huge bureaucratic mess if not expertly engineered and administered.

32.3:
The uncontrolled proliferation and duplication of expensive technology in our present system, considered by some the sine qua non of U.S. high-quality care, both adds to cost and detracts from quality.

Evaluation: Quite true; there are more MRI machines (Magnetic Resonance Imaging) in the state of Nevada than in the entire nation of Canada. And nearly all of them are underutilized.

33.1:
For example, because we have too many mammography machines, each is underutilized.

Evaluation: True.

33.2:
This doubles the cost of each test.

Evaluation: True.

33.3:
As a result, many women cannot afford the screening.

Evaluation: True.

33.4:
Thus, because we have too many mammography machines, we have too little breast cancer screening.[73]

Evaluation: It follows.

34.1:
For technically complex procedures, an inverse relationship between volume and mortality rates has generally been observed.[74]

Evaluation: True. Practice makes perfect.

34.2:
Yet, in the RAND appropriateness study, one fourth of the surgeons performing carotid endarterectomies did only one such procedure per year (on Medicare patients).

Evaluation: True.

34.3:
Three of four surgeons performed fewer than 10 endarterectomies—the average annual number performed by these surgeons was 3.4, a number most would consider too few to maintain proficiency.[75]

Evaluation: True.

35.1:
Hospitals compete for patients by establishing competing specialized services rather than cooperating to establish one high-quality unit.

Evaluation: True. The marketing imperatives.

35.2:
Two decades of "regional planning" requiring certification for more costly capital expenditures have shown that, absent more direct financial control of capital allocations, such regulatory efforts have not succeeded.[76]

Evaluation: Possibly true.

36.1:
Reorientation toward macroallocation broadens quality horizons in many ways.

Evaluation: It may.

36.2:
Establishing "fences" that prospectively define available resources means that less energy and money are wasted micromanaging each decision, and more energy is directed toward overall quality.[77]

Evaluation: Again, it may..

36.3:
A child scolded to clean his plate because there are starving people in Africa may reasonably question the logic.

36.4:
Refusing intensive care treatment to an elderly patient because the resources could be better used for prenatal care is similarly hard to justify if we lack a structure to redirect the resources.[78]

Evaluation: True.

36.5:
Global budgets allow managerial energies to be directed away from maximizing revenue, improving market share and expansion, toward improving quality.

Evaluation: True, but the industry is still largely a private, for-profit industry, and many are extremely leery of anything looking like "a government takeover."

37.1:
Competition gurus rely on report cards to allow marketplace choices to drive competition toward better quality.

37.2:
They overestimate the precision of measurements at the level of the individual provider or health plan (*New York Times.* March 31, 1994: A1, A11)[79] as well as the higher "leverage" potential of coordinated system improvement.

Evaluation: True. There is very little science in these evaluation devices.

37.3:
Because existing measures lack precision, cost may end up being the only "objective" measure.

Evaluation: True.

37.4:
Berwick[80] has argued that quality needs to be induced rather than selected.

Evaluation: True.

37.5:
Measuring performance ought to be aimed more at improving quality than at lubricating competition.

Evaluation: Others would counter that competition will beget the highest quality, as it has in many other industries..

37.6:
Such improvement requires leadership committed to improving each component of the system as well as coordinating its various elements.

Evaluation: True. Expert leadership, though; caring is not enough.

Sub-argument assessment: This argument is at the core of the controversy. To many it smacks of "socialism" and indifferent central control by faceless and unaccountable bureaucrats. While macroalloaction has appeal in principle, it is not compelling that it can only work through federal planning and implementation. There are examples of thriving regional vertically integrated health care systems such as Utah's Intermountain Health Care that strive to optimize resource utilization. Furthermore, there are apparent paradoxes evident; we cannot know what MRI's and other high technology tools would cost—or that they would be available at all—in the absence of the free enterprise economy that seems to spur their development. Are "socialist" societies significant developers of new drugs, therapies, and technologies, or are they typically consumers of such goods? This is an open question.

■

38.1:
9. Quality requires prevention.

Evaluation: I agree.

38.2:

Prevention means looking beyond medical treatment of sick individuals to community-based public health efforts to prevent disease, improve functioning, and reduce health disparities.

Evaluation: True. See below.

38.3:
These simple goals, articulated in *Health People 2000,*[81] remain elusive.
38.4:
Nine preventable diseases are responsible for more than half of the deaths in the United States, yet less than 3% of health care spending is directed toward prevention.[82]

Evaluation: True.

39.1:
Private health insurance attaches funding only to individual patients and thus separates the funding role and control from that of representing broader societal interests.[83]

Evaluation: True.

39.2:
Insurance companies discovered risk factors, such as hypertension,[84] yet they used this insight primarily to exclude high risk individuals.

Evaluation: True.

39.3:
This fragmenting of the community places both sick people and the social causes of disease outside the boundaries of medical care.
39.4:
Although rhetorically "prevention is cheaper than cure," many preventive measures probably increase costs.[85]

Evaluation: True. A more healthy young person stands a better chance of eventually becoming a very old, very ill person. Something on the order of 80% of a person's health expenditure takes place in the last six months of life. The older, the more expensive the care, typically. Good preventive medicine will likely therefore mean an increase in very old, eventually very ill people to be cared for.

39.5:
This, combined with high patient turnover rates and short-term financial orientation, gives private insurors little incentive to invest in prevention.

Evaluation: True, but, again, a solution is to improve quality so as to reduce the turnover rate.

40.1:
Health care financing should facilitate problem solving at the community level.

Evaluation: True. This would be a social good.

40.2:
Community-based approaches to health promotion rest on the premise that enduring changes result from community-wide changes in attitudes and behaviors as well as ensuring a healthy environment.[86,87]

Evaluation: True.

40.3:
Stores that refuse to sell tobacco to minors and promote low-fat foods, schools that teach avoidance of human immunodeficiency virus infection, and a health department that can guarantee clean air and water have a more vital role in ensuring health than does private health insurance.

Evaluation: Equally vital. The best private insurors do, however, promote individual and community wellness.

40.4:
According to Enthoven,[88] the originator of managed competition, its "goal is to divide providers in each community into competing economic units."

Evaluation: True.

40.5:
Capitation payments to competing providers, in theory designed to motivate prevention, thus fracture the community and make community-based interventions more difficult because no provider has a population-based purview.

Evaluation: True.

Sub-argument assessment: An emphasis on prevention is indeed warranted, irrespective of the ironies it implies. As an ethical principle, advancement of the public health should be a guiding value. However, while it is true that a fragmented health care industry may be impeded in focusing on prevention issues, it does not follow axiomatically that the only alternative is a national single-payer system. There appear to be viable alternatives.

■

41.1
10. Affordability is a quality issue.

Evaluation: So defined.

41.2:
Effective cost control is needed to ensure the availability of quality health care both to individuals and the nation.

Evaluation: True.

41.3:
Good quality care should not mean expensive care; if it does it will not be available to most citizens.

Evaluation: True.

41.4:
Flawed cost control reduces quality in many ways.
41.5:
It diverts resources from legitimate health needs, increases iatrogenic risks, and leads to financial barriers to care.

Evaluation: True.

41.6:
These harmful impacts derive both from failure to contain costs and "side effects" of ill-conceived cost control measures.

Evaluation: True.

42.1:
Despite multiple cost-control measures during the past two decades, costs continue to escalate.

Evaluation: True, but the rate of increase is slowing significantly. Some would say that market corrections are working.

42.2:
These measures have failed to slow growth of administrative costs, improve efficiency, curb ineffective or marginally effective services, or rein in excessive managerial or professional salaries or profits.[89,90]

Evaluation: True in many instances, probably not totally accurate.

42.3:
Moreover, many cost control initiatives have encouraged providers to discriminate against less profitable patients and increase their focus on fiscal rather than clinical goals.

Evaluation: True.

43.1:
The most prevalent approach to containing costs has been patient "cost sharing."

Evaluation: True, in what remains of the fee-for-service sector.

43.2:
Financial barriers have serious quality-impairing potential unless they are adjusted to patients' need for care and ability to pay.[91,92]

Evaluation: True, but the phrase "ability to pay" is a hot-button phrase with a lot of negative implications in the minds of many.

43.3:
It is impossible to erect a barrier high enough to discourage unnecessary care, low enough that needed care is not deterred, and simultaneously adjusted to a patient's discretionary income.

Evaluation: True. We end up with endless paper-pushing and administrative haggling.

43.4:
Donabedian[91] argues that "even if such adjustments were made, financial barriers would remain too blunt an instrument for assuring a precise calibration of care to need."

Evaluation: True.

43.5:
The RAND Health Insurance experiment confirmed this, finding that "changing economic incentives can alter the amount of care consumed, but implementing such measures appears to increase or decrease proportionately both appropriate and inappropriate use."[46]

Evaluation: I would agree.

Sub-argument assessment: While it is true that the free market in health care has resulted in pricing more and more people out, it remains to be seen whether a publicly planned and administered national system can deliver. Such a system might end up continually hostage to the political/budgetary process in Congress. There is no reason to believe the special interest pleadings would disappear. A continued wrangle over what gets coverage, and at what level of compensation, could very well be the case.

■

CONCLUSION

44.1:
Private insurors have regularly sought cheaper care, and to avoid paying beneficiaries' bills, but have rarely advocated better quality care for patients.[93]

Evaluation: Often true, but somewhat overstated.

44.2:
Health reformers in the United States should heed lessons learned in other industries.

Evaluation: Yes, they should.

44.3:
An obsession with cutting costs rather than with quality leads to both suboptimal care and higher costs.

Evaluation: This has been proven over and over again.

44.4:
Systems based on trust and common purpose achieve far more than those based on barriers and competition.

Evaluation: True.

44.5:
In addition, solutions that tamper with a system, increasing complexity, are inferior to those that simplify the way a job is done.[52]

Evaluation: True. Each additional process step adds potential for error.

Sub-argument assessment: Again, while argument 44 is valid, it does not perforce mandate the superiority of a federal single-payer system.

■

45.1:
Health-financing reform provides a pivotal opportunity to improve the quality of health care.

Evaluation: True. But, once again, that does not require that a national public program is the only workable solution.

45.2:
We believe that a single payer national health program provides the most effective framework for implementing the quality-enhancing principles discussed above.

Evaluation: It is possible, but not beyond dispute.

46.1:
A managed competition strategy, such as that proposed by the Clinton administration and debated in Congress, while designed to provide universal access, has not demonstrated an ability to contain cost and creates a complex structure with separate and unequal mutlitiered care.

Evaluation: False. The strategy has not yet been tried, to speak of it in the past and present tense is to substitute theory for data.

46.2:
Eschewing the easily enforceable budgetary constraints of the single-payer approach necessitates reliance on potentially damaging financial incentives, wasteful micromanagement, and complicated budgetary regulation to minimize spending.

Evaluation: Not necessarily.

46.3:
Accountability, achievable only if patients are maximally empowered and involved, is structurally nurtured by an open and publicly controlled funding process and impeded under managed competition by multiple intermediaries between providers and patients.

Evaluation: True, accountability is nurtured by an open and honest process, but it does not automatically follow that it *must* be publicly financed. There may be, and in fact there are, workable private alternatives.

46.4:
Effective implementation of computers in clinical medicine would be retarded by pecuniary interests favoring proprietary data and incompatible software formats and enhanced by public development, ownership, and standards.

Evaluation: While this is true, no one should underestimate the magnitude of the difficulties involved in constructing a massive, secure, reliable national medical computer system.

46.5:
Global budgeting facilitates directing national resources based on the needs derived from these epidemiologic data, whereas competition ensures that resource allocation will depend on profitability.

Evaluation: True, but this again smacks of "central planning" that has at best a spotty track record.

Sub-argument assessment: Again, the inherent superiority of single-payer to the viable alternatives is asserted but not compellingly demonstrated. Utah's IHC is in "managed competition," but their model is less like that characterized by 46.1 and more attuned to the principles of health care CQI as advocated by the authors.

■

47.1:
No amount of regulation and oversight can breathe quality into a system that is not based on caring professionals working for patients.[26]

Evaluation: True.

47.2:
There is little empirical evidence that report cards and regulatory constraints can reliably separate "good" from "bad" care.

Evaluation: True.

47.3:
The technical capabilities of such measures are too imprecise, and incentives for gaming are too great (*New York Times.* March 31, 1994:A1, A11).[56,79,94]

Evaluation: True.

47.4:
(.a) Such measures encourage mindless efforts to meet concrete, but in many cases tangential, criteria while emphasizing sanctions and policing, **(.b)** which run counter the CQI principles that empower workers think innovatively about processes.

Evaluation: True.

47.5:
Regulation cannot revitalize a system controlled by financial institutions driven by fiscal incentives both efficiency and fraud, quality care as well as neglect of patients' problems.

Evaluation: True.

47.6:
More regulatory and administrative overhead does mean less time and resources for patient care.

Evaluation: True.

Sub-argument assessment: While true, argument 47 adds no support to the "single-payer-is-best" overall conclusion.

■

48.1:
A single-payer system is not a panacea for resolving these problems.

Evaluation: No, it would likely not be.

48.2:
What it does offer is a framework for collectively engaging these issues in a fair, cohesive, and effective fashion.

Evaluation: Possibly true, but it could also bog down in endless political infighting.

48.3:
The 10 principles outlined above, while neither a detailed blueprint of how a U.S. single-payer system would work nor a point-by-point critique of alternate reform proposals, suggest that important opportunities to improve quality would be compromised were the United States to settle for a managed competition approach.

Evaluation: I agree with this, if we mean "managed competition" as set forth in the Clinton reform proposal.

Sub-argument assessment: Here the authors only "suggest," and properly so, for it is not at this point incontrovertible that private managed care inherently risks compromised quality.

■

49.1:
Rather than being a code word for the status quo, quality must become a pivotal guide for change.

Evaluation: True.

49.2:
A unified system emphasizing cooperation, democratic accountability, and explicit planning is preferable to a fragmented approach with accountability abdicated to success or failure in the market and planning forsaken in favor of resource allocation based on profitability.

49.3:
Only this preferred approach to system redesign can lead us to a qualitatively better system, one that instills a sense of ownership and pride in its patients and providers.

– Alternative wording that combines 49.2 and 49.3 for clarity:

(49.2+49.3).alt:
Only a unified health care system re-design approach emphasizing cooperation, democratic accountability, and explicit planning can lead us to a qualitatively better system, one that instills a sense of ownership and pride in its patients and providers, one preferable to both the staus quo and all of the proposed alternative reforms.

Evaluation: The conclusion is debatable.

Sub-argument assessment: *Only* a unified health system? The authors go from "suggesting" in 48.3 to declaring that "only" the single-payer system they advocate can yield a better system, one superior to realistic alternatives. A quick leap up in certainty.

■

Overall Evaluation:

The following alternative courses of action are generally advanced in the health care debate:

1. Status quo: the system works fine, and normal incremental quality improvements at the provider level will suffice. Get a job.
2. Insurance reform: prohibit exclusion and enforce community rating to reduce the insurance premium stratification characteristic of the present system.
3. Expand existing public payer programs such as Medicare to cover the working poor and otherwise uninsurable.
4. Capitated managed competition, with "employer mandates" to provide choices in beneficiary alliances for pooled coverage buying power, administered though the workplace.
5. Tax inducement programs such as the "Medi-save" approach in which workers use pre-tax dollars to purchase catastrophic coverage and pay for routine health expenses themselves.
6. The public single-payer system based more or less on the Canadian model.

No one can dispute that the health care industry can be improved. *Any* system can be improved. Problems such as lack of access, arbitrary and often wildly excessive pricing, inexplicable variations in clinical practice and outcomes are well-documented and cry out for solution. That tends to rule out option 1. The question is one of extent; has the case been made that the health care industry requires comprehensive national reform?

Option 2: Many see the problem as an insurance reform issue rather than a health care reform issue per se. The debate brings us face to face with fundamental questions about the nature of private insurance. Where do we draw the line on the freedom to assess and underwrite risk? Is health care insurance ethically different from insuring cargo? Part of the image problem health insurors have is self-inflicted; arbitrary, unscientific risk assessment, payment denials and delays, and the financial imperative to "cherry-pick" (attempting to only contract with those posing minimal risk) have made insurors objects of suspicion and resentment. Insurors uniformly bemoan their meager financial returns, yet even a cursory examination of their real estate, furnishings, portfolios, and executive salaries (not to mention their highly visible and aggressive "Harry & Louise" lobbying against reform this past year) tends to discredit their apologies.

Option 3: U.S. Representative Pete Stark proposed exactly this: it was called "Medicare, Part-C" and would via Medicare expansion insure the working poor not eligible for Medicaid nor otherwise insurable. This option would extend more nearly universal coverage but would do nothing about the chronic cost-shifting that is prevalent in health care financing. It would also fail to address the cost-containment problems seen in the existing program. This proposal was seen by the insurance industry as a "trojan horse" for an eventual single-payer system, and, as such was successfully lobbied down.

Option 4 is exactly what comprised the Clinton legislative proposal for reform. It proved inscrutably complex. Having seen the 1,400-odd page text of the proposal, I am skeptical of its byzantine complexity. those 1,400+ pages would have necessitated something on the order of millions of pages of implementing policy regulations, with all the potential for bureaucratic gridlock they might effect.

Option 5: "Medical IRA's" are a favorite of conservatives, and have considerable theoretical merit. The central idea is that, when people directly spend their own money, they tend to be smarter shoppers, and this would control prices. Third party payment for health services tends to reduce the incentive to ride herd on costs. But health care encounters are not the psychological equivalent of shopping for a new VCR, and becoming an informed health care consumer is not at all easy. And finally, these Medi-save accounts would do nothing for those without jobs (if they are to be funded via pre-tax employment compensation), or for those whose taxable incomes are so low as to nullify the tax incentive. The Medi-save approach would have to be supplanted by additional programs for those it would not touch.

Option 6, Single-payer: Using the Canadian example as a model for U.S. reform has a couple of liabilities. First, the U.S. population is roughly ten times the size of Canada's; we would be engineering a vastly larger institution, and there may well be unforseen dis-economies of scale. Our record in the operation of large public bureaucracies is considerably less than stellar. Secondly, there is considerable reputable disagreement with respect to the relative virtue of the Canadian system. Many Canadians (and not only wealthy ones) routinely come to the U.S. for treatment, and there are additional documented signals of increasing dissatisaction in Canada. It is a more humane system in that it covers everyone by entitlement, but it does significantly impact the cost of living in Canada. There is reason to believe that same or worse would be the case here, at least in the relatively near term.

The envisioned unified computerized data system such an institution would require could well be a development nightmare that might be in many respects obsolete before it went on-line. The documented inadequacies of both the IRS and FAA computer systems stand as a warning. The sheer volume of health care data proposed for on-line storage and access is daunting. An article in Byte Magazine earlier this year detailed the CPR system (Computerized Patient Record) under development at Brigham & Womens' Hospital in Boston, and revealed that the *daily* data storage requirement was approximately 3.5 gigabytes! (3.5 billion bytes) Remember, this is for *one* institution. Constructing a single national health care data system would be fraught with a breadth of imposing technical and policy difficulties. It would require the latest hardware, the finest software development teams, and an unprecendented level of policy agreement and guidance.

In sum, the authors' argument has many strengths, particularly in their exhaustively documented enumeration of the shortcomings of our present health care system—to the extent to which it can be characterized as a "system." There is, however, a plausible alternative to a public national single payer system that would meet many of the goals sought by these advocates, and it is not a theoretical one. Utah's IHC (Intermountain Health Care) organization is a private, vertically-integrated health care corporation serving Utah and western Wyoming residents. It is a large for-profit network of hospitals, clinics, physicians, and related operations such as home health services. IHC is essentially a managed-care system with subscribers who pay set fees and minimal co-payments. Unlike other HMO-type operations in the state that

typically experience subscriber turnover rates of appoximately 15% per year, IHC's turnover rate is less than 0.5% (that's 0.005), at competitive prices. They accomplish this by an organization-wide, enthusiastic, almost religious commitment to the very CQI principles outlined above. IHC quality improvement programs are directed by Dr. Brent James, a surgeon and nationally respected leader in health care CQI education. Having myself undergone their health care CQI training course over the period of the past six months as a part of my work, I can attest that IHC, while not yet perfect, effectively applies nearly all of the recommendations cited in this article, albeit on a smaller scale (and that may indeed be a significant virtue). They are in essence a microcosmic single-payer system, but one successful in the private sector, driven not by publicly imposed mandates, but by their own thorough knowledge of and dedication to CQI. It is difficult to see at this point whether the asserted advantages of a national public system would add net value beyond the type of operation that IHC represents.

To be fair, IHC operates in a fairly prosperous, culturally homogeneous region enjoying a great deal of social and political unity. Here in Nevada, by contrast, though we share a common border and similar population size and geography with Utah, the social milieau could not be more different. IHC might not encounter the same level of success in other regions, and their successes do not impact those who cannot obtain coverage—and a central issue of this article has been about the significant negative impact of such a deficit. The IHC example does, however, stand in stark relief to both the inadequate business-as-usual attitude, and the proposition advanced above that a national single-payer system is the best path to effective health care reform. Other examples exist around the nation also; one that comes to mind is Northwest Hospital in Seattle, whose presentation at the Annual Quality Congress of the American Society for Quality Control this year revealed yet another organization deriving signficant cost savings and quality improvement from diligent application of CQI methods.

Rule Number One of CQI is "listen to the customer," and thus far the customers are prohibitively wary of the idea of greating a huge new national program, a political reality that is unlikely to shift anytime soon. The argument presented by Schiff et al takes into account an enormous amount of evidence and theory generated from *within* health care and the wider quality sciences, but serious questions remain unresolved with respect to the needs and concerns of health care consumers, whose overwhelming support would be needed to implement a single-payer health care system.

Robert E. Gladd

December 15, 1994