HEALTH CARE REFORM: THE RIPPLE EFFECT

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It is hard to doubt that there is a widespread movement toward change regarding health care in the country. It is hard to detect when it started; it is obvious that we are in the midst of change but difficult to know where, difficult to know how much or how quickly change will cause recognizable difference. Some point to the upset senatorial victory of Harris Wofford in Pennsylvania as being the watershed. Others believe that for the last decade or so there has been foment.

Taking a longer view, there has been change, there is change and there will be change. Indeed the purpose for speculating whether there has been change, that there is change or that there will be change, is to determine the effect and magnitude of that change. It almost seems redundant to enunciate change, but there are certainly milestones. The politicians did indeed get the message from the Wofford upset, that the public did want change in their health care system. They knew health care costs were rising and this impacted the cost of their policies. They knew that it was getting more and more difficult for people to qualify for health insurance policies, and with more and more small businesses unable to afford health insurance policies for their workers, it was risky changing jobs without the guarantee of health insurance. Indeed, it was known that over 70% of the uninsured did in fact have jobs, but that those employed persons did not qualify for health insurance, did not want health insurance or could not purchase health insurance.

In this cluster of three articles, there is a theme and that is of the predicting of change. I have asked Rachel Block, the Executive Director of the Vermont Health Care Authority, to describe the change that is occurring in her state and using that as a potential example of what could occur in many of the states. In the next article, Barbara Edwards and Linda Karlovec are predicting the magnitude of change in the insurance industry, and in the final article of the cluster, I have challenged myself to come up with as short a characterization of the change that will occur in the health care delivery system, namely accountability.

In the last quarterly edition of 1993, the Journal of Insurance Medicine will be more specific on health system reform. We expect that the President's Health Reform will be announced September 22. Up until this point, it has been difficult to predict exactly when the plan will be announced. The various partial announcements, such as the briefing to the Democratic members of the House and the President's speech to the National Governors' Association, are not detailed enough on specific choices to warrant writing a cluster of articles. We hope to have commentary on the President's plan for health system reform. We will also include articles on state health reform.

Predicting Change

The Vermont Health Care Act of 1992 (Act 160) did not come about in isolation. Indeed, by 1992 state law makers, health care providers, consumers and employers all had a great deal of experience in the varying fields of reform. The first article in this cluster on health care reform outlines the specifics of the Vermont experience since the bill was enacted.

The Vermont experience, writes Leichter, challenges the wisdom concerning coalition building. He gives as an example the trade-offs between the acceptance by Vermont physicians of global budgets and practice parameters, in exchange for malpractice reform, reduction in governmental micro-management and decrease in paper-work from providers.

Physicians, hospital administrators and business groups see a market-based system with managed care in a managed competition environment, rather than the current system or a Canadian-style single payer system, as being preferable.

The legislature in involving these mini-coalitions has as its trade-off situation to decide some fundamental issues such as the level of health care that each Vermonter will receive, and how universal access will be funded?

The health system reform initiative as, a whole, conceived a progression of steps which most importantly included the formation of the Vermont Health Care Authority (VHCA). Some of the other steps include: Standard forms for billing of services, an expenditure target, the abolition of community rating, plans for universal access and the increased medical teaching programs, output of primary care physicians. Specifically, in terms of the universal access question, there is a trade-off with providers in exchange for malpractice and tort system reform. The VHCA believes that its Integrated Delivery Systems will improve access, increase the quality of care and improve health of Vermonters while still assuring choice of providers in a cost con-
tained system. The Integrated Systems of Care are comprised of networks of providers, facilities and administrators under one management structure. There would be a Vermont Uniform Benefit Plan (VUBP) and a Vermont Health Care Purchasing Trust. This latter entity/ies would be public-private partnerships to act as agent and advocate for the payers and consumers of health care services. The VHCA has also been instructed by the legislature to develop two models, one a single payer model and the other a public-private partnership.

Predicting the Magnitude of Change

The insurance industry, say Edwards and Karloveč, has a problem with its public image and has lost a degree of public trust. They say that there is a call to change; a challenge to redefine the insurance business from catastrophe and financial management to future management. Firstly, they point to health insurance and indicate that the industry, in responding to a call for a price solution, has increased consumer cost-sharing, hardened underwriting standards and increased scrutiny of utilization. Whilst for the majority, this may have resulted in slowing the rate of premium increase, it has disenfranchised more. This in turn has made the problems worse and not better, as judged by consumers who value access to health services.

The authors turn to automobile insurance and draw parallels to the health insurance market, both in terms of consumer demand for cost control and assured access to affordable services (in this case, a car) but also in terms of industry.

The life insurance market, from their perspective, is also changing. Financial security in the face of increased economic uncertainty and access to long-term care are major issues for the future. Changing consumer perceptions of value will no longer be met by traditional products. The authors argue that responding to this call for change will require new relationships so that insurance companies can impact the systems that impact consumer's future security. They conclude with comments on the potential providers of future management and the process for redefining the business. They indicate that the changes may be broad and fast. In this conclusion, they are clearly supported by events currently taking place in Europe. The remarkable success of Direct Line, started by Royal Bank of Scotland in 1985, which by the end of 1993 will likely become the largest motor (automobile) insurer and is rapidly growing in household (home owners) insurance in the United Kingdom demonstrates how quickly market control can shift. Following on from Direct Line, both Royal Insurance and Guardian Royal Exchange have entered that distribution system.

In addition, Edwards and Karloveč note that the insurance industry may be faced with the need to impact the health care system to meet consumer expectations of product value in not just the health market, but in the auto and life insurance markets as well. Although they do not cover worker's compensation in their analysis, the same can be said for that market; medical costs are among the fastest growing segments of expense and loss costs.

The authors suggest that unless the industry acts to meet the consumer's need for future management, the public's call for fundamental reform of the health care financing and delivery system may yet be seen in other product lines.

Predicting the Meaning of Change

The third article in the cluster, "Accountability: Dimensions of a Challenge" attempts to inter-relate the various areas that come into play with accountability. It starts off by pointing out that a Donabedian quality assurance model, while being quality assurance for the provider, may be viewed as accountability model for the consumer and for the payer, in any event, a one dimensional model. By adding the consumer, in terms of patient satisfaction and general well-being to the Donabedian model and at the same time focusing particularly upon outcome, a second dimension is added and the model becomes an Ellwood type of outcomes management model. Dimensions of disease, added to the two dimensional model, turns it into a three dimensional model which then has many of the characteristics of the so called "report cards" either of the HEDIS or Jackson Hole Group types. The hypothesis of the article is that this "four dimensional" model can be used either focused on particular populations, disease or wellness enhancing entities or provider. This model also has relevance to individual practitioners and places outcomes management in appropriate context. The model can also be used in estimating training and future training needs.

References