

*A new way must be found to improve the functioning of our health care system that does not rely on central guidance, that draws instead on the creativity and will of the American people, working in their communities.*

## I. INTRODUCTION

The American health care system seems in an accelerating downward spiral: wasteful, unsustainably costly, inadequate in quality, and unable to protect millions against the financial burden of illness. Yet, national leadership for reform is stymied by ideological and political gridlock. A new way must be found to improve the functioning of our health care system that does not rely on central guidance, that draws instead on the creativity and will of the American people, working in their communities. Through a several year study, including community forums throughout the United States, the Harvard Interfaculty Program on Health Systems Improvement came away inspired by the potential for grass roots leadership to reform our health care system. In a time of national pessimism about health care problems, our local forums, the Harvard Forums on Health, found glimpses of hope in the native ingenuity and creativity of communities around the United States. This document presents a vision for reform that aims to capitalize on that local potential, and to use it as a springboard for comprehensive solutions to seemingly intractable national health care problems.

The Harvard Forums on Health concentrated on local innovations relevant to the nation's most pressing health care issues:

- disease prevention focusing on obesity
- racial and ethnic disparities
- management of chronic illness, with a particular focus on mental health
- covering the uninsured, and
- controlling rising health care costs

At each event, the Forums brought together stakeholders, including Americans personally affected by these problems, grassroots service providers from innovative organizations that offer promising solutions, health services researchers, and policy experts, to discuss the broader implications of these innovations cultivated at the local level.

A sixth and final Forum focused on developing the concepts for this report, namely:

1. Articulating a comprehensive framework for how to catalyze and support the kind of regional efforts identified at the previous Forums,

*In essence, the Harvard Forums on Health have provided an initial roadmap for construction of national health reform from the bottom up, building from local and state innovation to systemic change.*

2. Facilitating pilot projects in ten states or regions to simultaneously tackle these pressing health care issues, and
3. Adopting proven state innovations at the federal level.

This comprehensive framework — envisioned as a twenty-year strategy of phased activities — includes specific goals related to issues of coverage, quality, affordability, value, and population health. It builds upon the current administration's health proposals and recommends specific roles and responsibilities of the states and federal government. In essence, the Harvard Forums on Health have provided an initial roadmap for construction of national health reform from the bottom up, building from local and state innovation to systemic change. Such a roadmap offers a sound policy framework for the development of bipartisan consensus on ways of improving our health care system at a time of national health care crisis.

Only at the local level can stakeholders develop effective partnerships that can integrate care across disconnected health care settings and between the private and public health systems.

## II. THE HARVARD FORUMS ON HEALTH: FOCUSING ON LOCAL INNOVATIONS

The Harvard Forums underscored the important notion of local communities functioning as laboratories for innovation and testing, assessing what does and does not work before broader adoption. The Forums found that many communities are ready to move forward on their own, recognizing that for the time being, they cannot count on outside help to deal with a dysfunctional health care system. The Forums further identified that local initiative is fundamental to optimizing health care system progress. Only at the local level can stakeholders develop effective partnerships that can integrate care across disconnected health care settings and between the private and public health systems.

This integrative function is particularly important for the growing numbers of chronically ill patients who traverse a “system” that has rudimentary or non-existent ways to reliably transfer patient information and to coordinate care.<sup>1</sup> The notion of coordination between the individual and public health systems holds out the promise of addressing the many factors that fall outside of the confines of the system but have dramatic effects on health, for example, patient behavior, environmental exposures, and social/cultural circumstances, among others.<sup>2</sup> Finally, coalitions can serve as collaborative instruments for change in a community.

One of the major issues raised in the Forum on mental health, for example, was that patients were often lost as they transitioned between social, health care, and government services and that inefficiencies arose when patients received duplicated and poorly coordinated services from these various sources. *Wraparound Milwaukee*, one of the innovations highlighted in that Forum, was designed to address these quality and redundancy problems by pooling the resources used to care for emotionally disturbed children in the mental health, juvenile justice, child welfare, and special education systems. Because this type of coordination would be impossible for a single group to spearhead, *Wraparound Milwaukee* requires a coalition of city and county actors collaborating around an agreed upon set of goals in order to succeed.

*Understanding the attributes of successful programs identified through the Forums and elsewhere can yield helpful lessons to policymakers as they develop an approach to reform from the bottom up.*

Finally, the Harvard Forums underscored the importance of setting up a parallel evaluation effort so that policymakers can rely on evidence compiled over time as they recommend which innovations to spread to the broader regional or state level, and eventually across the country. More often than not, local efforts go unstudied and unknown, while similar communities struggle to design programs to address vital issues. Understanding the attributes of successful programs identified through the Forums and elsewhere — regional programs that managed to survive and flourish in complex political and social environments where proposals for big national programs have made little headway — can yield helpful lessons to policymakers as they develop an approach to reform from the bottom up. In addition, understanding what specific, crosscutting environmental barriers local regions face is important information for national policymakers as they contemplate how they might remove obstacles to innovation through federal policy and legislation.

The Harvard effort is not alone in focusing the lens on the local community and states as building blocks for more comprehensive, national change. For example, two recent Institute of Medicine (IOM) efforts — *Fostering Rapid Advances in Healthcare: Learning from System Demonstrations* and *The First Annual Crossing the Quality Chasm Summit: A Focus on Communities* — both stress state and regional efforts as leading the way to more far-reaching change. Also, the Department of Health and Human Services' *Steps to a Healthier US* has awarded close to \$50 million dollars to 40 local communities to form multi-stakeholder partnerships and coalitions to prevent obesity, diabetes, and asthma at the community level (<http://www.healthierus.gov/steps/>). The lessons from these communities and their successes will help to guide thinking about prevention. Collectively, these efforts point the way toward a new approach to providing relief to our nation's most pressing health care issues. This report recognizes and builds on these efforts.

*The authors propose a set of steps over a twenty-year period that will put our nation on a course towards a health care system that assures universal health insurance coverage to all Americans, provides optimal quality of care, is affordable, assures improvements in population health, and provides the greatest possible value for health care expenditures.*

### III. VISION FOR REFORM

Health system reform has been a political topic for almost a hundred years, and yet, with a few obvious exceptions, there has been little comprehensive change. However, evidence is accumulating that the health care system is out of control, growing more costly at an unsustainable rate, and leaving more and more Americans without access to even the most basic services. With no relief in sight, major change is at once desperately needed and difficult to effect.

Any attempt at change must start with the elaboration of a vision of what an improved health care system should look like. Agreement on that vision would provide vital grounding and milestones for reform proposals. We also think that the process of developing agreement on a vision may reduce antagonisms in a polarized political environment and create opportunities for cooperation where so few seem to currently exist. It is often the case that Americans can agree on ideals, even when they cannot immediately reach concord on the methods for translating those ideals into policy.

This section sets out a proposed vision for our future health care system, including quantitative goals whose accomplishment would signal achievement of that vision. The vision is inspired by, but departs from, the framework laid out in IOM's report, *Crossing the Quality Chasm* in that there is emphasis on both the public and private health systems, more of a focus on value for expenditure and affordability, and an emphasis on the importance of communities and states as vital building blocks to more comprehensive national change.

The authors offer a vision that is sufficiently challenging to encourage our most thoughtful, creative efforts, and also sufficiently realistic to be attainable. They propose a set of steps over a twenty-year period that will put our nation on a course towards a health care system that assures universal health insurance coverage to all Americans, provides optimal quality of care, is affordable, assures improvements in population health, and provides the greatest possible value for health care expenditures.

In the section that follows the vision we present several "building block" strategies, staged over time, to achieve these goals when the political will to act materializes.

## Articulating the Vision: Stated Values and Goals

---

### COVERAGE

#### Vision Statement:

We envision guaranteed health care coverage for all Americans in twenty years.

#### Rationale:

This goal may be construed as the enabling step for health system change. At the heart of health system change is financial protection for all against the costs of illness. Uninsurance, as Arthur Kellermann, co-chair of the IOM committee on the Consequences of Uninsurance, asserted at our Chicago Forum, is destabilizing for the whole health care system. It also flies in the face of public opinion, which overwhelmingly supports health insurance security for all.

#### Baseline:

- 45 million Americans (17.7%) were uninsured in 2003; 9.1 million children (11.8%) were uninsured in 2003.<sup>3</sup>
- 51.4 million Americans (17.9%) had been uninsured at some point in the previous year; 11.8% of children under 18 were uninsured at some point in the previous year.<sup>4</sup>
- 28.8 million Americans (10.0%) had been uninsured for over a year at the time of the interview; 4.7% of children under 18 had been uninsured for over a year at the time of the interview.<sup>5</sup>
- Price-tag for 2004 uncompensated care provided by private and public health care institutions is estimated at \$41 billion, two-thirds of which is funded by federal dollars.<sup>6</sup>

#### Measures of Success:

- 100% health insurance coverage for children under 18 in 5 years.
- 100% health insurance coverage for adults over 55 in 10 years.
- 100 % health insurance coverage for all Americans in 20 years.

---

### QUALITY

#### Vision Statement:

We envision a health system that provides safe, effective, patient-centered, timely, efficient, equitable care to all.

#### Rationale:

Americans do not receive the care they need. Over-utilization and under-utilization of health care services create a dangerous environment which harms tens of thousands of patients every year. We often have

*We envision guaranteed health care coverage for all Americans in twenty years.*

*We envision a health system that provides safe, effective, patient-centered, timely, efficient, equitable care to all.*

*We envision a health care system in which individuals can afford to purchase protection against the costs of illness.*

the technical and professional expertise to provide needed care, but because of fundamental problems in the way care is organized, that expertise is not translated into high quality services. The IOM report, *Crossing the Quality Chasm*, outlines four reasons that our systems fail us when it comes to quality. These include the growing complexity of science and the rapidly growing knowledge base; the increase in chronic conditions, and the need to move away from acute treatment; the poorly organized health care delivery system; and the sluggish adoption of information technology systems.

**Baseline:**

- For preventive care, patients received approximately 55% of recommended care indicators. Acute care patients received 54% of recommended care processes, and 30% of acute care patients received contraindicated care. Chronically ill patients received 56% of the recommended care processes, and 20% of these patients received contraindicated care.<sup>7,8</sup>
- Patient safety, a class of quality problem, has received considerable attention, and it has been estimated that 1% of hospital admissions resulted in an adverse event due to negligence. Preventable adverse drug events were estimated to occur at a rate of 1.8 per 100 hospital visits, and 20% of those were life-threatening.<sup>9</sup>

**Measures of Success:**

- Reduce the number of inpatient medical errors by 85% in 20 years.
- Reduce the number of overall inpatient and outpatient medication errors by 90% in 20 years.
- Achieve 95% compliance with evidence-based guidelines for management of chronic illness in 20 years.
- Eliminate racial and ethnic disparities in management of chronic illness in 20 years.

---

**AFFORDABILITY**

**Vision Statement:**

We envision a health care system in which individuals can afford to purchase protection against the costs of illness.

**Rationale:**

The cost of health insurance is growing rapidly, consuming an ever increasing portion of Americans' wages and disposable income. Uncovered health expenses and out of pocket spending is also growing. The unaffordability of health insurance and health care threatens the availability of coverage and the financial stability of the American family. Finally, lack of health insurance coverage has a disparate impact

*We envision a health system that achieves quality and safety targets while constraining the rate of growth in health care expenses.*

on African Americans and Hispanic Americans, which contributes to their poorer health outcomes. Goals and solutions must not enlarge these disparities.

**Baseline:**

- Medical costs increase at approximately 1% per year above GDP.<sup>10</sup>
- National health expenditures have risen steadily over the last decade, representing 12.0% of GDP in 1990 and 16% in 2004. Per capita health expenditures rose from \$2,737 in 1990 to \$5,670 in 2003.<sup>11</sup>
- From 1980 to 2001, the number of health-related bankruptcies increased 23-fold.<sup>12</sup>
- 46.2% of personal bankruptcies representing between 1.9–2.2 million Americans, were attributed to major medical causes, while 54.5% of personal bankruptcies were attributed to any medical cause.<sup>13</sup>
- 38.4% of individuals who file for personal bankruptcy report having a health insurance lapse in the two years leading up to filing.<sup>14</sup>

**Measures of Success:**

- The number of health-care related bankruptcies in the United States should be reduced by 95% in 20 years.
- The number of Americans citing the expense of health insurance as a reason for declining coverage should be reduced by 95% in 20 years.

---

**VALUE**

**Vision Statement:**

We envision a health system that achieves quality and safety targets while constraining the rate of growth in health care expenses.

**Rationale:**

As noted in the quality section, our health care system does a poor job of providing high quality, safe medical care. In addition, the United States pays a lot for its health care, and the costs continue to rise. Most recently, we have seen employers, the traditional purchasers of health insurance, passing larger shares of this rising cost onto their employees, and experts agree that this trend will continue.

**Baseline:**

- As indicated by previously cited data on cost and quality, the United States does not get sufficient value for money invested: its health care system is extraordinarily expensive, but major remediable gaps in quality and safety persist.

*We envision a health care system that materially improves population health and proactively addresses the environmental, behavioral, mental, and physical causes of poor population health.*

### **Measures of Success:**

- Within the next 20 years, the United States health care system should achieve the quality goals described above while keeping the rate of growth in real health care expenditures equal to 2% or less.

---

## **POPULATION HEALTH**

### **Vision Statement:**

We envision a health care system that materially improves population health and proactively addresses the environmental, behavioral, mental, and physical causes of poor population health.

### **Rationale:**

Many disabling diseases are exacerbated by the personal behaviors of Americans and by missed opportunities to prevent the development of these behaviors and the physical deterioration that occurs as a result. Obesity is one of the most compelling examples of this behavioral dimension of our health, but other behaviors like smoking, avoiding vaccinations, and not engaging in preventive screening, can also contribute to poorer future health outcomes. Appropriate mental health screening at the primary care level offers the potential to begin treatment of these debilitating conditions, but depression and other mental illnesses are seriously under diagnosed.<sup>15</sup>

In general, many Americans are poorly served in terms of preventive care because our health care system is designed inadequately to realize the benefits of preventive services. Financial incentives are scanty when it comes to screening and counseling; medical students are trained primarily with the infectious or acute incident model; and much of the responsibility for preventive care devolves to the individual. Finally, many of the conditions that can be addressed in population health measures disparately affect minority populations. Care needs to be taken to ensure that goals and solutions do not widen these disparities.

### **Baseline:**

#### *Obesity*

- There has been a 50% increase in rates of obesity in the US since 1990.<sup>16</sup>
- 65% of adults in the US are overweight or obese and 30% of Americans over 20 (over 30 million Americans) are obese.<sup>17</sup>
- 16%, or 9 million, children and teenagers are overweight, which triples the rate in 1980.<sup>18</sup> In addition, African American and Hispanic children are at greater risk of being overweight than their white counterparts.<sup>19</sup>

#### *Smoking*

- 28.5% of high school students report current cigarette smoking.<sup>20</sup>
- 22.5%, or 46 million, adults in the US smoke cigarettes.<sup>21</sup>

Many of the conditions that can be addressed in population health measures disparately affect minority populations.

- This issue ties into the disparities issue, as 32.9% of people with incomes below the poverty line are smokers, compared with 22.2% of people with incomes at or above the poverty line. In addition, Native Americans have the highest smoking rates among any racial or ethnic group, at 40.8%.<sup>22</sup>

#### *Asthma prevention and control*

- 7.5%, or 16 million, adults in the US suffer from asthma. In addition, racial and ethnic disparities exist in prevalence of this condition, as 11.6% of Native Americans and 9.3% of African Americans suffer from asthma, compared to 7.6% of whites.<sup>23</sup>
- Native Americans and African Americans are more likely to report symptoms of uncontrolled asthma, including emergency department visits and experiencing limitations in activity.<sup>24</sup>
- 12%, or nine million, children in the US suffer from asthma; poor children are more likely to be diagnosed, and African American children are more likely to report an asthma attack.<sup>25</sup>

#### **Measures of Success:**

##### *Obesity*

- Rate of growth in obesity for adults and children will be reduced by 50% in 20 years.
- Decrease in the proportion of overweight and obese adults to 50% in 20 years.
- Reduce the proportion of obese adults to 20% in 20 years.
- Reduce the proportion of overweight children to 11% in 20 years.

##### *Smoking cessation*

- Reduce the adult smoking rate to 12% in 20 years.
- Reduce teenage smoking to 15% in 20 years.

##### *Asthma prevention and control*

- Reduce hospitalization from asthma for people aged 5-64 from 12.5 per 10,000 to 5 per 10,000 in 20 years.
- Reduce hospitalization from asthma for people over 65 from 17.7 per 10,000 to 8 per 10,000 in 20 years.
- Reduce hospitalization from asthma for children under 5 from 45.6 per 10,000 to 15 per 10,000 in 20 years.
- Reduce emergency department visits for asthma for people aged 5-64 from 71.1 per 10,000 to 40 per 10,000 in 20 years.
- Reduce emergency department visits for asthma for people over 65 from 29.5 per 10,000 to 10 per 10,000 in 20 years.
- Reduce emergency department visits for asthma for children under 5 from 150 per 10,000 to 60 per 10,000 in 20 years.

*We recognize that there is disagreement about both what is desirable for the US health care system, and how to achieve the challenging but attainable vision for a transformed health system that we have laid out.*

## IV. A MULTI-STAGED STRATEGY FOR IMPLEMENTING CHANGE

We recognize that there is disagreement about both what is desirable for the US health care system, and how to achieve the challenging but attainable vision for a transformed health system that we have laid out.

The political system is conservative by design, and the current political environment is polarized. Consequently, consensus on across-the-board health system change will be difficult to achieve. Trust in institutions continues to fall, with trust in the federal government especially low, leading individuals to be more suspicious than ever about the motives of the government in proposing avenues for change. Economic realities also severely limit the options. Federal and state budget pressures mean there is less funding available for expensive, comprehensive programs; and an increasingly competitive global economy puts pressure on businesses to lower production costs, in particular the rising costs of employee benefits. Competition for federal health care money will intensify as the baby boom generation approaches retirement, and likely will be exacerbated by record tax cuts. Finally, terrorism and the war distract citizens and politicians from domestic ills.

However, there is also rising discontent with the health care system, and health care concerns are increasingly entering the public consciousness. Health care figured prominently in the presidential debates during the 2004 campaign, and conventional wisdom suggests that the issue is expected to be front and center in the 2008 campaign. Suffering associated with the cost of care and declining insurance coverage is growing, and the price of drugs and shortages in influenza vaccine have personalized health care issues in a way that has rarely occurred in the history of health care debates. Problems with the implementation of Medicare's new drug benefit have also galvanized popular interest in health issues. Finally, Americans are more aware of other countries' lower priced health care as senior citizens and others travel across the borders for drugs and affordable health services. It is our belief that the health care environment will continue to worsen at an accelerating pace.

How bad can it get? How much will the American people tolerate before they demand change? No one can answer these questions. But it is reasonable to predict that health system reform — a term to which we do not ascribe a particular policy agenda or approach — will become ever more salient and

*In this model, state and local governments will act as regulatory enablers, while private stakeholders — large anchor corporations, local health plans, major health care providers, unions, consumer groups — will provide leadership and expertise to launch local health care reform.*

compelling as a public policy issue, an issue that private and public leaders can no longer postpone, ignore, or avoid. Our premise, therefore, is that we must develop innovative strategies for reform, strategies that have the possibility of uniting contending political factions, sooner rather than later. These strategies must be ready for implementation when the tipping point in our national discussion is reached.

The remainder of Section IV lays out some options that we feel should be considered when the time is right for broad health system reform, which we expect is at least five years off. In the meantime, we advocate the following short-term initiatives as building blocks to the day when we can implement more comprehensive solutions:

1. *Identifying and disseminating information on promising local innovations*, like the ones spotlighted in the Forums, and the findings that are beginning to emerge from the Medicare demonstration projects. A national clearinghouse of local innovations, organized by goal, would be an appropriate vehicle for this approach.
2. *Adopting consensus goals that envision the health care system our nation would like to see*. This process could be led at the federal, state or local level. It should involve public and private stakeholders, including provider groups, employers, health plans, accrediting organizations, state and local health authorities, and national health care leaders. These goals should be concrete and quantifiable.
3. *Investing in both innovation and evaluation, especially those efforts spearheaded by state and local governments*. Too often local efforts go unstudied, and then communities and states have little evidence to guide their resource allocation for current innovations, and to inform decisions about whether to spread such innovations to other geographic areas.
4. *Strengthening current legislative proposals to bring them in line with the consensus goals*. Evaluations of ongoing state and local programs can guide policymakers as they attempt to improve their own programs, and remove barriers to reform.

With these principles as a guide, the participants in the final Forum designed a sequenced series of stages that will achieve the vision for a transformed system over a twenty-year period.

### **Stage One — Strengthening and Leveraging Existing Efforts**

The first stage of this multi-staged strategy — to take place outside of the Washington beltway — is to stimulate and support local and regional health care innovation directed at our key goals of coverage, quality, affordability, value, and population health improvement. Ideally, such local programs will provide comprehensive health care solutions to local populations, leveraging

*The first stage of this multi-staged strategy — to take place outside of the Washington beltway — is to stimulate and support local and regional health care innovation directed at our key goals of coverage, quality, affordability, value and population health improvement.*

local resources. In this model, state and local governments will act as regulatory enablers, while private stakeholders — large anchor corporations, local health plans, major health care providers, unions, consumer groups — will provide leadership and expertise to launch local health care reform. This strategy, likely driven in each community or state by a multi-stakeholder coalition, will not be appropriate for all locations, but will provide a broad range of options for self-selected locations.

More specifically, we believe that our national government should contribute to and stimulate local innovation by creating a competitive process, in which appropriate, interested localities can bid to receive matching federal seed money to initiate their innovation. The anchor corporations, local health plans, local philanthropic organizations, research universities, and others will match the seed money and provide specific business plans that present detailed information about how each entity will fulfill its roll in the proposal. Federal and state governments will provide regulatory relief if appropriate and will help to evaluate whether the plan can fulfill its stated goals.

In addition to this focus on local and regional innovation, the *first stage* of this multi-staged strategy would also involve the implementation and refinement of several proposals advanced by recently elected leaders in the Executive and Congressional branches of our federal government. These relatively modest proposals are consistent with the current political climate and offer potential for progress if properly designed and implemented. Specifically, over the next five years, this strategy advocates strengthening the tax credit and health savings account (HSA) approaches through careful elaboration of all the options and developing devices to mitigate possible unintended consequences and by evaluating these programs to see how well they perform in terms of reaching coverage, population health, and cost goals. In addition, the national legislature should enact medical litigation reform, including caps on attorneys' fees and limits to compensation for pain and suffering. This type of reform may help drive down health care costs, which could make health insurance more affordable and decrease the misuse of medical care. Tort reform would also enhance the health care system's quality and safety by facilitating sharing of information about defects in health care delivery.

More specifically, the first step of this process will involve explicitly linking the tax credit, HSA, and tort reform proposals to the long-term goals outlined in the previous section. For example, tax credits alone will bring us closer to meeting the coverage goals, but the level of the credit and the dissemination strategy used will dramatically affect the rate of take-up and, ultimately, the success of this approach in reducing the number of uninsured Americans. Significant research has been done to identify the optimal amount of tax credit to increase coverage while minimizing concomitant crowd-out of the employer-based health insurance market. In 2004, 9% of the US population in the individual market opted for HSAs, while 74% whose only recourse was the individual market opted not to take-up health insurance.<sup>26</sup> However, in a simulation of the Bush administration's proposal of a maximum tax credit of \$1,000 for low income single adults, Feldman, et al. found that the number of uninsured would decline by 2.9 million as the

*Our state-based approach envisions federal leadership and broad direction for change, but with more specific ideas, planning, and implementation from states and localities.*

percentage of individuals taking up HSAs doubles. They estimated the cost at \$2,761 per person.<sup>27</sup> Further, they modeled take-up rates if the entire premium for the HSA was covered for uninsured low-income taxpayers, with increasing premiums with income. This simulation reduced the number of uninsured by 4.5 million, and cost \$2,718 per person.<sup>28</sup> Gruber, et al. caution that the structure of the credit is essential to determining its success.<sup>29</sup> For example, low levels of tax credit result in fewer uninsured taking up health insurance. Additionally, the structure of the credit, including when the credit is issued, drastically affects take-up.

The impact of HSAs is less clear as they are a relatively new insurance product, so long-term data are unavailable. However, one argument is that HSAs, at least for the first few years, will mainly shift insured individuals from one insurance product to another, rather than accessing uninsured individuals. There may be ways, however, to make HSAs more attractive to the uninsured, including packaging them with a preventive care component, or including tax credits as part of the payment mechanism. In addition, there may be ways to strengthen the HSA structure to ensure that less qualified health consumers are not exploited by unscrupulous insurance plans or health care providers. Finally, tort reform will provide some cost savings, but it is necessary to ensure that injured patients continue to benefit from the protection of the law. It is also important that we have reasonable expectations about the short- and long-term cost savings that medical liability reform will provide.<sup>30</sup>

## **Stage Two — Phasing in a Federalist Approach to Reform**

The second stage of the strategy will involve phasing in a federalist, or state-based, approach to meet the goals — leveraging lessons from Stage One. This stage will begin in 5 to 10 years. Henry Aaron and Stuart Butler previously elaborated a similar approach in considerable detail.<sup>31</sup> Their important work in this area has informed our thinking.

We suggest a federalist, or state-led, strategy for health system reform for multiple reasons. First, our Forums convinced us of the size and diversity of the nation's health care system, the level of innovation that is occurring at local and state levels, and consequently the desirability, indeed necessity, of encouraging and stimulating state and local leadership in health care reform. Our state-based approach envisions federal leadership and broad direction for change, but with more specific ideas, planning, and implementation from states and localities.

We propose that the federal government offer funding and tools to help ten states experiment with innovations to meaningfully advance national goals. This federalist solution will have the following key elements:

- State plans must commit to achieving quantifiable, five year goals for expansion of health insurance coverage, and at least one other domain of the vision outlined above (e.g., quality, affordability, value, population health).

*The federal government will adopt a set of national health care goals related to coverage, quality, value, affordability, and population health to be achieved over a twenty-year period.*

- The federal government will provide 50% of the funds needed to achieve the states' goals. State plans must encourage innovation at the local level, including explicitly demonstrating the involvement of employer groups, provider groups, and payers. This involvement could include the creation of a public/private health care innovation council, or other body.
- The plans must include an evaluative component, including highlighting specific measures by which the plan will be evaluated, and specifying funding requirements appropriate to carry out these evaluations.
- Sub-state entities (such as counties, cities or regional authorities) may apply for the state funds if the state fails to apply, if the entity can raise matching funds and if it demonstrates that it can achieve population-level goals for the specified community or area of the state.

The state-based experiments will fulfill two key roles. First, they will attempt to improve the health of their populations by meeting the goals; and second, they will provide innovative, proven ideas for other states to replicate or build from. As part of the *stage two strategy*, the federal government will adopt a set of national health care goals related to coverage, quality, value, affordability, and population health to be achieved over a twenty-year period.

The federal government, working with the states, will support plans that put the states, and the nation, on a trajectory to achieve the aforementioned twenty-year goals. As indicated below, overall plans for achieving twenty-year goals will lay out interim goals that will be achieved over 5- to 10-year periods.

Examples of such goals and appropriate time frames follow.

---

## **COVERAGE**

The national goal is to reduce the number of uninsured from 45 million to 30 million over 10 years after the start of Stage Two.<sup>32</sup>

- Estimated costs for covering 15 million uninsured over 10 years: \$99 billion – \$201 billion.<sup>33</sup>

---

## **QUALITY**

The federal government will specify quantifiable goals for safety and quality targeted over five years after the start of Stage Two. These might include goals that reconcile medications across the continuum of care and goals that speak to the improvement of performance according to the quality measures specified by HEDIS, the National Quality Forum, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or similar sources.

### **For example:**

- Goals pertaining to medical errors might specify reducing the number of inpatient deaths due to medical errors by 40%<sup>34</sup> within 5 years.

*The state-based experiments will provide innovative, proven ideas for other states to replicate or build from.*

- Additionally, goals might stipulate progress in the reduction of overall inpatient and outpatient medication-related errors and reducing the number of medication-related deaths from 7,000 to 4,000 within 5 years.
  - Because information on the prevalence of medical errors is currently incomplete, we do not have a satisfactory baseline. Thus, when the state plan is approved, the first step for a state in meeting this set of goals would be to measure the baseline rate of various kinds of medical errors. A number of states are in the process of doing this currently.
- Goals pertaining to accurately and completely reconciling medications across the continuum of care might stipulate, per the JCAHO:
  - Develop a process for obtaining and documenting a complete list of the patient's current medications, including comparing the medications the organization provides to those on the patient's list.
  - Communicate this list within and across settings of care.
- Other goals might include the adoption and effective use of best practice approaches, nationally recommended screening and immunization policies, and agreed-upon practice guidelines.
- Finally, states might propose quality measures that focus on at-risk groups. For example, states could focus on strengthening the patient-provider relationship in publicly funded health plans by stipulating reasonable patient loads for providers and reasonable visit times.

---

## **AFFORDABILITY**

State goals in this domain might take the following form:

- Controlling premium prices for an actuarially comparable benefit package to a specified rate of increase above medical inflation (for example, 2%) over a 10-year period, starting with initiation of Stage Two, or,
- Fulfilling a series of structural or process targets under the assumption that these measures will control rates of increase in health care costs. For example, within 5 years of the beginning of Stage Two:
  - States could put in place technology assessment processes that affect all insurance providers.
  - States could take steps to assure that 50% of all physicians use electronic medical records.
  - States could take steps to assure that state-certified disease management programs were used by 50% of all chronically ill patients.

*Our recommendations regarding funding assume that problems become acute enough so that the political will to invest in health care change materializes at both the national and the state level.*

---

## VALUE

The *value* domain will be satisfied with the achievement of quality and safety targets while controlling the rise in cost of premiums paid by individuals in the state. Thus the value goal will be realized when quality and affordability goals are realized. Alternatively, states could undertake new investigations that document increasing return on investment to health care dollars spent on individuals in their jurisdictions.<sup>35</sup>

---

## POPULATION HEALTH

By focusing on some priority conditions and health behaviors, we may expect to see greater returns in terms of the national burden of disease and its concomitant costs. States can focus on a few population health measures in order to address this domain. For example,

- *Obesity*: decrease the proportion of overweight and obese adults to 60% from the baseline of 65% over 10 years from the start of Stage Two.
  - *Tobacco use*: Reduce adult smoking to 20% in 10 years.
  - *Asthma*: Reduce emergency department visits for asthma for children under 5 from 150 per 10,000 to 80 per 10,000 in 10 years.
- 

## FUNDING

Funding is always problematic when meaningful national goals are set. Our recommendations regarding funding assume that problems become acute enough so that the political will to invest in health care change materializes at both the national and the state level. Nevertheless, since we assume that state participation is voluntary, we acknowledge that the diversity of political cultures in the United States will result in wide variation in the willingness of states to respond to federal leadership and federal offers of funding support.

---

Our state-based strategy is not a universal or mandatory strategy, any more than the Medicaid program was universal or mandatory. Recall that Arizona did not join the Medicaid program until twenty years after it was enacted. It should also be recognized that if, at first, substantial numbers of states decide not to participate, the immediate funding burden on the federal government will be reduced. At the same time, if only a small fraction of states step forward and commit to major reform, that will in itself be instructive. Recall again that the enactment of the Medicare and Medicaid programs followed on a much more limited attempt to provide health care for the elderly through a state-based, means tested approach called the Kerr-Mills legislation. Only after this effort failed did the political will emerge

*Indeed, it may be argued that before such national solutions can even be considered in our federal system, the states must be given a chance to solve the problem themselves.*

to enact a comprehensive, legislative national solution. Indeed, it may be argued that before such national solutions can even be considered in our federal system, the states must be given a chance to solve the problem themselves.

Under the state-based strategy, the federal government will set aside sufficient funds to provide long-term (10-year) support for state and locally initiated health system reform. The funds will be administered through the Department of Health and Human Services. In addition, a nonpartisan commission will be established to advise the Secretary in reviewing and approving state plans and in allocating the necessary funds. Federal funding will be commensurate with the stated goals, but will not exceed \$113 billion over 10 years.<sup>36</sup> States will compete to be approved for funding and receive approval in waves: for example, a maximum of 10 states approved each year over a five year period. This would somewhat reduce the immediate impact on the federal budget.

The authors are agnostic concerning precisely how these revenues would be raised at the federal and state levels: a variety of mechanisms exist, including progressive income taxes, augmented sin taxes, and other varieties of sales taxes. However, we do not believe that deficit financing should be used at the federal level. And, state requirements to balance budgets largely preclude the use of deficits at this level of government.

Participating states and localities would be required to develop concrete plans to meet the state-specific versions of the national goals. These plans could take into account variations in state and local situations with respect to national goals. For example, states with low rates of uninsured citizens might be expected to exhibit greater improvement on quality, value, or population health indicators. The federal government can facilitate achievement of goals through certain actions, including making a separate pool of the Federal Employees Health Benefits Program (FEHBP) available for state citizens if the state plan encourages enrollment in FEHBP for the purpose of improving affordability, choice, and coverage; providing federal tax credits towards the purchase of health insurance for individuals in states or localities with approved plans; granting exceptions to ERISA requirements; or by promoting exemplar practices through research and development and the dissemination of information about best practices.

The success of this stage of the plan rests with the states. This is strategic, in that it responds to several of the feasibility issues raised above: citizens have more confidence in the motivation of state government action than in the federal government; the leadership at the state level is more aware of and responsive to the needs of their constituents, so the problems and the solutions seem far less abstract; finally, there are fewer barriers to quick action, so states can respond swiftly and flexibly to developing problems. In addition, states have experience dealing with their specific environment, so they are familiar with the local business community, they have direct experience in providing services to very low-income populations, and they are more aware of the particular cultural milieu of their constituents which, to some extent, sketches the boundaries of what is possible.

*A third stage of the strategy, to be implemented in fifteen to twenty years, would involve the implementation of effective state-based programs throughout the United States, with continuing funding partnership and guidance from the federal government.*

Participation in the plan would be voluntary on the part of states. They can secure participation by developing and submitting a plan that meaningfully advances nationally developed health care goals. However, in situations where states choose not to participate, the federal government will have the option of considering plans developed and submitted by communities or regions of non-participating states, so long as these entities have the capacity to raise matching funds. Thus, counties or cities are most likely to qualify.

In order to be qualified for federal funding, we expect that state plans will have to meet certain minimal requirements, including the following:

- The state will develop a health care reform proposal that explicitly commits to achieving the national goals adapted to local circumstances.
- State plans must commit to addressing the coverage domain and one other area, or, if they are at or near the uninsured goal, they can commit to addressing two of the other domains.
- The state will provide 50% of the funds needed to achieve the state's goals.
- State plans must encourage innovation at the local level, including explicitly demonstrating the involvement of employer groups, provider groups, and payers. This involvement could include the creation of a public/private health care innovation council, or other body.
- The plans must include an evaluative component that highlights specific measures by which the plan will be evaluated and specifies appropriate funding requirements for carrying out these evaluations.

### **Stage Three — Implementation of State-Based Programs throughout the United States**

A third stage of the strategy, to be implemented in fifteen to twenty years, would involve the implementation of effective state-based programs throughout the United States, with continuing funding partnership and guidance from the federal government. In other words, the successes of Stage Two will lead to Stage Three, as more battle-tested, creative solutions are available for states to model. This trickle-down experimentation will allow states to match their cultural views, statewide health profile, and political will with their obligation to meet the health-related goals documented above.

States that come late to the health care reform table will have the benefit of 15 to 20 years of systematic experimentation with local and state level health system reforms addressing the nation's most fundamental health care problems. Those experiments will have been carefully evaluated, the results published and thoroughly vetted, and the strategies themselves will have become familiar to the American people. A cadre of experienced health policy leaders will exist in both the public and private sectors that can testify to the strengths and weaknesses of alternative approaches, and will be available to implement change throughout the United States. In other words, the intellectual and human capital necessary for effective change will be ready and

waiting for a more comprehensive effort at health system change, whatever form that effort ultimately takes. We further expect that this eventual program of reform will continue to rely heavily on state management, will provide considerable autonomy to state government, and will consist of varied solutions to common problems across the United States.

*The successes of Stage Two will lead to Stage Three, as more battle-tested, creative solutions are available for states to model.*

*It is our view that, one way or another, fundamental health care reform must occur.*

## V. CONCLUSION

By proposing a multi-staged process that is directed toward the achievement of measurable goals and involves a range of interested constituents, we are putting forth a practical politically feasible bipartisan plan. However, this strategy is experimental, in that local- and state-level health system programs may not be enough to reach the agreed upon goals. In this event, and if health system failure continues apace, the public views toward the role of government in health care and the attractiveness of alternative solutions may change.

It is our view that, one way or another, fundamental health care reform must occur. We propose here a bottom-up solution that is consistent with the current political climate. Should that climate change fundamentally, perhaps in response to the progressive collapse of our private health insurance system and widespread uninsurance and underinsurance among middle-class Americans, then it may become possible and necessary for the federal government to play a more aggressive leadership role. If this is required, the federal government will also have the benefit of an extensive period of experimentation with a wide range of strategies.

Policy-making, like politics, should be viewed as the art of the possible. The current climate cries for action, but the political climate determines the form such action can take. We believe that the program we have outlined will improve the lives of Americans in ways that foster learning, prepare us for all eventualities, and precludes no options as changes in our health care system unfold over the next twenty years.

## Footnotes

- 1 Gandhi TK, Sittig DF, Franklin M, Sussman AJ, Fairchild DG, Bates DW. Communication breakdown in the outpatient referral process. *J Gen Intern Med* 2000; 15: 626–31.
- 2 McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Affairs* 2002; 21(2):78–93.
- 3 Holahan J and Ghosh A. The Economic Downturn and Changes in Health Insurance Coverage, 2000–2003. Kaiser Family Foundation. 2004.
- 4 Cohen RA, Hao C, Coriaty-Nelson Z. Health insurance coverage: Estimates from the National Health Interview Survey, January–March 2004.
- 5 *ibid.*
- 6 Collins SR, Davis K, and Lambrew JM. Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals. *The Commonwealth Fund Publication #671*. 2004.
- 7 McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003;348:2635–45.
- 8 Schuster MA, McGlynn EA, and Brook RH. How good is the quality of health care in the United States? *The Milbank Quarterly* 1998; 76(4): 517–563.
- 9 *ibid.*
- 10 Chernew M, Cutler DM, and Keenan PS. Increasing health insurance costs and decline in insurance coverage. *Health Services Research* 2005; 40: 1021–1039. This cost estimate is based on CMS' assumption.
- 11 Kaiser Family Foundation. *Trends and Indicators in the Changing Health Care Marketplace*, 2003. 2005.
- 12 Himmelstein DU, Warren E, Thorne D, and Woolhandler S. MarketWatch: Illness and injury as contributors to bankruptcy. *Health Affairs* 2005; Web Supplement: W5-63-W5-73.
- 13 *ibid.* For context, approximately 4 million debtors and dependents declared bankruptcy in 2001.
- 14 *ibid.*
- 15 See McGinnis JM, *et al.* for a thoughtful discussion of the benefits and difficulties of designing a program to address some of the nonmedical influences on health.
- 16 Flegal KM, Carroll MD, Ogden CL, Johnson CL. Prevalence and trends in obesity among US adults, 1999–2000. *JAMA* 2002; 288:1723–7.
- 17 *ibid.*
- 18 Hedley, AA, Ogden, CL, Johnson, CL, Carroll, MD, Curtin, LR, Flegal, KM. Overweight and obesity among US children, adolescents, and adults, 1999–2002. *JAMA* 2004; 291:2847–2850.
- 19 Centers for Disease Control and Prevention. Surveillance Summaries, May 21, 2004. *MMWR* 53(No. SS-2).
- 20 CDC. Youth Risk Behavior Surveillance System. *MMWR* 2002; 51(19):409–12.
- 21 CDC. Cigarette smoking among adults—United States, 2002. *MMWR* 2004; 53(20):428–431.
- 22 *ibid.*
- 23 CDC. Asthma prevalence and control characteristics by race/ethnicity — United States, 2002. *MMWR* 2004; 53: 148.
- 24 *ibid.*
- 25 Dey AN, Schiller JS, Tai DA. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2002. National Center for Health Statistics. *Vital Health Stat* 2004; 10(221). 2004.

- 26 Feldman R, Parente ST, Abraham J, Christianson JB, and Taylor R. Health Savings Accounts: Early estimates of national take-up. *Health Affairs* 2005; 24(6): 1582–1591.
- 27 *ibid.*
- 28 *ibid.*
- 29 Gruber J and Levitt L. Tax subsidies for health insurance: Costs and benefits. *Health Affairs* 2000; 19(1): 72–85.
- 30 In 1995, medical malpractice costs comprised less than 1% of total health care costs. (Viscusi WK and Born P. Medical malpractice insurance in the wake of liability reform. *The Journal of Legal Studies* 1995; 24: 463–490.) While this percentage may have risen, it is doubtful, given other cost drivers, that it is substantially greater today. Experts have found that innovative state-based medical liability systems, like that in California, which include stringent caps on noneconomic damages, do slow the increase in medical malpractice insurance rates.
- 31 How federalism could spur bipartisan action on the uninsured. *Health Affairs* 2004; Web Supplement: W4-168–78.
- 32 Holahan J and Ghosh A.
- 33 Based on estimates by Hadley J and Holahan J. Covering the uninsured: How much would it cost? *Health Affairs* 2003; Web Supplement: W3-250-65.
- 34 Kohn LT, Corrigan JM and Donaldson MS, eds. *To Err is Human: Building a Safer Health System*. National Academy Press 2000, p. 31. Annual inpatient deaths due to medical error were estimated to range between 44,000 to 98,000.
- 35 For example, see discussion in Cutler DM. *Your Money or Your Life: Strong Medicine for America's Health Care System*. Oxford University Press, 2004.
- 36 This cost estimate was derived by assuming that insurance coverage would cost between \$99 and \$201 billion, of which the federal share would be \$50 to \$100 billion. An additional \$500 million per state is estimated to cover the costs of the quality, value, cost, and population health programs that a state might undertake, of which the federal share would be \$12.5 billion (if all states chose to take-up the program). Thus, the outside estimate is approximately \$113 billion.