HEALTH CARE REFORM
FROM THE
NATION TO THE
NEIGHBORHOOD

By Linda Anderberg
These days, everyone is talking about health care reform. Depending on whom you ask, you might hear any of the following: Our health care system is severely fragmented. It trails most other major industries in terms of technology and organization. Costs are spiraling out of control. The United States spends more money on health care than any other industrialized nation with arguably worse health outcomes.

Forty-seven million Americans remain uninsured. In addition, our system is responding slowly to the challenges of an aging population living with a growing level of chronic disease. There is just not enough focus on prevention and public health. It’s increasingly clear that the health care system is not just due for a tune-up; it needs a major overhaul on every level. So it’s no surprise that as the 2008 election approaches, health care is one of the top domestic issues on the minds of the voters. And politicians, professors, and health care professionals are responding. The School of Public Health, with its mission of improving health, is well situated to contribute meaningfully to reform—thinking strategically about current and future problems, evaluating existing policies and procedures, generating new solutions, and translating research into results.

What’s Happening in Washington?

When it comes to reforming health care, Professor of Health Policy Helen Halpin might be characterized as something of an overachiever. When the California Health and Human Services Agency called for proposals to reform health care and improve access in the state, Halpin submitted two. One, the CHOICE option, which Halpin developed (with the help of “an incredible group of outstanding women in health care in California,” she says) outlines a framework that Halpin brought to Democratic presidential hopeful Barack Obama when she joined his Health Care Policy Committee as an unpaid adviser last summer. Halpin worked on five of the different subgroups of the committee, including public health intervention, cost containment, defining a public insurance plan, and increasing quality. She was recently designated as the surrogate on health care policy for Northern California, which means she will continue to handle press and speak to the public about Obama’s health care reform initiatives, and she contributes regularly to the blog Daily Kos on behalf of the campaign.

The CHOICE plan basically allows everybody to keep the insurance they have, but provides the option of a single-payer public plan, which operates alongside the existing system. The addition of a public plan is now a key component of the health care reform plans of the three leading Democratic presidential candidates—Hillary Clinton, John Edwards,* and Obama, although Clinton allows anyone to join the public plan, whereas under Edwards’s and Obama’s plans you may only join the public plan if you are presently uninsured, employed in a small business, have private individual coverage, or have inadequate coverage through your employer.

“As far as the Democratic candidates, what’s most interesting is the extraordinary consensus on the framework.” —Helen Halpin

“Almost everyone understands that a single-payer plan would be the most efficient, effective, equitable, and secure plan, hands down,” says Halpin. “But politically, it would be impossible to adopt. And it doesn’t make sense economically, because if we put everyone in the country in the single-payer plan, the insurance companies would be out of business overnight. It’s a huge sector of the economy, and you just can’t do that.”

Halpin envisions a slower transition to a single-payer plan, with the insurance industry still contributing to the reformed health care system by selling supplemental policies and performing administrative functions. She worked with the Lewin Group, a national health care and human services consulting firm, to model the CHOICE plan for California, and they discovered that within one year, 70 percent of the population would be in the single-payer plan. “The majority of the population would have more choice, lower costs, and better access,” says Halpin. “It’s a no-brainer, right?”

In addition to the public plan component, the leading Democrats’ plans each have a pay or play mandate for employers, a pool to connect individuals and small businesses to private insurance plans like members of Congress have, and each expands Medi-Cal and the State Children’s Health Insurance Program (SCHIP). “As far as the Democratic candidates,” says Halpin, “what’s most interesting is the extraordinary consensus on the framework.” Some differences are that Edwards’s and Clinton’s plans contain an individual mandate that would require every citizen to have insurance, whereas Obama’s does not. And Obama’s plan uses a direct subsidy model to help lower-income people pay for their premiums, while Clinton and Edwards use a tax credit model. In addition, Obama’s plan permits adult children to stay on their parents’ policy until they are 25 and offers a reinsurance program to stabilize premiums.

*As this issue headed to press, Edwards announced his withdrawal from the race.
The driving goal behind every Democratic candidate’s plan is to provide quality affordable health care for all. But what’s different from previous reform attempts is the variety of options people will have to achieve this goal. “There has really been a paradigm shift,” says Halpin. “We used to talk about national health care reform in one-size-fits-all terms. And I think what politicians and policymakers have realized over time is that Americans don’t like one-size-fits-all; we want choices. So in the past we’ve offered people choices of health plans or plans with more choices of doctors, but this time we’re actually offering choices of systems.”

The Democratic candidates’ sweeping plans for health care reform lead to an important question: What if a Republican is elected? Associate Professor of Health Economics Will Dow, who served on President Bush’s Council of Economic Advisors (CEA) when the administration was planning major health care reform, has some insight. “The Republican plans aren’t targeted at reducing the number of uninsured in the short term necessarily,” he says. “They’re targeted at trying to reduce cost growth. Average insurance premiums have almost doubled since 2000, which both exacerbates the uninsurance problem and increases the budgetary cost of proposals to expand insurance subsidies for low-income groups.”

When Dow served on the CEA, White House political advisers were focused on trying to reduce cost growth by making health consumers more aware of their spending. The idea was to make people more directly involved in paying for their health care, which would make them more price-sensitive, which in turn could lead to greater adoption of cost-cutting technologies and hence slow the growth of health care spending over the long term. “We know that a big chunk of technologies that people are developing aren’t really cost effective for many patients,” Dow says. “The theory is to change the priorities of technology developers so that they could profit not just from making better technologies that are more expensive, but also from making technologies that are more efficient. In practice we don’t yet know whether growth rates could be substantially slowed through significantly expanding cost-sharing, but Republicans argue that the approach merits trying.”

One mechanism to get people more involved in the cost of their health care is health savings accounts (HSAs), which provide tax savings to individuals who enroll in high deductible health insurance policies, thereby incentivizing cost sharing. HSAs were rolled out by the Bush administration before Dow’s tenure with the CEA, and expanding high deductible insurance through mechanisms such as HSAs are major components of the Republicans’ plans.

“If you really want to tackle the uninsurance problem in the long run, you have to address the health care cost issue,” says Dow. “You could put a band-aid on the uninsurance issues today or you could pass something to expand SCHIP, but any significant insurance expansion that gets passed today is going to cause serious budget headaches 10 years from now unless we can lower cost growth.”

The chances of any of this reform being enacted varies widely based on who gets elected, which party controls Congress, and when and how aggressively the new president pushes the legislation. For example, Edwards and Obama have promised to move on health care reform in the first year of their first term, while Clinton will wait until her second term. “If you introduce a bill for major change within the first three months of your presidency, your odds of success are 75 percent, which is huge,” says Halpin. “But if you wait until the end or your first year to actually introduce anything, it drops to 15 or 20 percent. So there is urgency here.”

Despite the obstacles, Halpin is cautiously optimistic that some badly needed reform can occur on a national level. “The politics are going to line up against any plan and the insurance and pharmaceutical companies are going to get their guns out,” she says. “But with any luck, this time the Democratic Party will be better prepared to counter a lot of the fear mongering. I think the public is tired of being made afraid of change or different ideas.”

Learn a Lesson from California

The health care reform struggle currently happening in California is a good illustration of the challenge of adopting comprehensive policy at any level. Compromise legislation on comprehensive reform was agreed to by Gov. Arnold Schwarzenegger and
Learn the Language of Health Care Reform

To help you frame the debate, here are the definitions of some terms that are used frequently in discussions of health care reform.

**Community Rating:** Under community rating, insurers have to charge the same price to every policyholder within a community, regardless of age, sex, or any other indicator of health risk. The premium is based on the average cost of providing medical services to all people in a specific geographic area. Under modified community rating, price differences could be based on age and/or sex.

**Connector, Bridge, or Pool:** These are state- or federal-sponsored programs that facilitate individuals and small businesses in purchasing products offered by private insurance companies. Small businesses and individuals lacking health insurance are eligible, and individuals at lower income levels may receive subsidies. Their goal is to provide continuous coverage for individuals regardless of employment status.

**Consumer-Driven Health Care:** Consumer-driven health care refers to health insurance plans that allow members to use personal health savings accounts, health reimbursement arrangements, or similar medical payment products to pay routine health care expenses directly, while a high-deductible health insurance policy protects them from catastrophic medical expenses. Funds not spent in a given year usually may be carried over to the following year.

**Guaranteed Issue:** Guaranteed issue requires that each insurer and health plan accepts everyone who applies for coverage and guarantees the renewal of that coverage as long as the applicant pays the premium.

**Individual Mandate:** Under an individual mandate, the state or country requires individuals to have health insurance. People who don’t receive such coverage through their employer or some other group are required to purchase their own individual coverage. Those who fail to do so are subject to fines or other penalties. Some individual mandates may exempt individuals who cannot afford to purchase insurance.

**Pay-or-Play Laws:** Pay-or-play refers to states mandating employers to pay a fee to the state to provide health insurance to their employees (to pay), unless the employer provides health insurance coverage directly to its workers (to play).

**Single-Payer Plan:** In a single-payer plan, the state or country becomes the single payer for all health care bills.
While the state politicians work on what Dow terms “the 30,000 foot framework of what needs to be done,” other organizations in California are already moving forward on some of the governor’s stated goals. Beyond insuring all Californians, Schwarzenegger’s administration is also focusing on prevention, wellness, and the treatment of chronic diseases, specifically diabetes. Tom Williams, executive director of the Integrated Healthcare Association (IHA) and a doctoral student at the School, has taken up this challenge.

Williams and the IHA are very committed to improving the quality of the health care system in California. The Pay for Performance (P4P) Initiative, now in its fifth year, has already achieved improvements across clinical quality, patient experience, and use of information technology. The next step for Williams is to bring the P4P program to bear on chronic disease management. “Most Pay for Performance programs to date have focused on primary care,” he says. “On the chronic disease side, there is tremendous opportunity to improve both the quality and cost of care, and that’s where we’re beginning to focus.”

Effective January 1, 2008, the IHA implemented a whole range of measures based on the coordinated care of diabetes patients, and doctors must score well on every measure in order to achieve payment. They’ve also included a set of measures called IT-Enabled Systemness. Together these two groups should act as a guideline and incentive for physicians to improve chronic disease management. Take, for example, diabetes registries. Williams explains, “In the absence of a complete electronic medical record, you can implement an electronic registry so that every single diabetic gets registered. Then you have 10 things that you take out of the medical record and put in this registry, including a foot check, eye check, blood pressure, blood glucose, etc. Now you can do population management, you can run reports, and you can have someone check periodically to ensure these tests get done. That’s just a simple example, but it’s very powerful.”

The P4P program provides bonuses to physicians who implement information technologies, including diabetes registries, population management reporting systems, and electronic drug prescribing, drug interaction checking, and retrieval of lab results. “You can see intuitively, if you can do all these things, that’s really going to help your ability to manage your practice,” says Williams. “This has really captured the attention of the physicians’ groups. They like quality; they think it’s the right thing. So they’re very much engaged.”

In addition to the continuing work with P4P, Williams and the IHA are working on a project on medical device use. Says Williams, “Once there’s FDA approval of a device or drug, then there’s not sufficient oversight, record keeping, or tracking of how things are going. So IHA is managing a demonstration project just to better understand medical device use and the relationship between the device companies and the surgeons and hospitals.”

A veteran of medical group and health plan management, Williams came to the School of Public Health to get his Dr.P.H. and refocus his career on his two main interests: quality improvement and managing health care costs. “If you’re working for a for-profit company, it becomes about making money,” he says, “which is fine. But I just felt like I needed to get into the nonprofit world and develop some skills so I could focus on what I wanted.” Fortunately for patients, his focus is on helping improve the health care industry.

Local Reform on a Daily Basis

It might seem counterintuitive, but School of Public Health alumnus Tony Iton, health officer and director of the Alameda County Public Health Department (ACPHD), believes health care system improvements have the best chance of happening on the local level. “Sometimes I wonder where the state and national fit in,” he says. “Because frankly, there is a difference between health care and health care insurance. Health care is delivered to individuals in communities through a delivery system, and that delivery system doesn’t change because a politician had a bright idea. It’s based on the local environment in which it is found.”

Iton, who earned his M.P.H. at the School and also has graduate degrees in law and medicine, puts his education to work every day for the residents of Alameda County. “I wake up each morning trying to figure out ways to make one and a half million people healthier today than they were yesterday,” he says. “It’s a huge intellectual challenge, and it’s a huge structural challenge.”

Local health organizations are also taking a cue from the governor’s agenda and focusing on better
strategies for treating chronic disease. Alameda County is one of a handful of counties that applied for state money to participate in a pilot project called the Health Care Coverage Initiative, which is designed to test innovative ways to provide health services to the uninsured. Iton’s department is working with the patients in the county’s safety-net population who have diabetes, high blood pressure, or congestive heart failure—chronic diseases that drive a large proportion of health care dollars. They are looking at the cost of treating those patients, including hospitalization, clinic service, emergency room visits, and drugs, and finding ways to manage that care more effectively and cost efficiently. One major way is to make sure that every one of those people has a “medical home,” which is a concept in health care reform of linking people to a place where they can get care information 24 hours a day, seven days a week. Not just a doctor, but a medical assistant, a nurse, and disease management experts who will manage a group of patients—being available by phone, checking in with patients and facilitating their participation in peer groups, and hooking people up with any technology that is cost effective and can help patients manage their health.

“These kinds of things really give the patient more control over his or her situation,” says Iton. “The literature demonstrates that it is linked with much better outcomes. Meaning in general less hospitalization, less emergency room utilization, less death, and therefore less cost and increased productivity amongst patients with chronic diseases.”

Iton’s department is implementing new place-based strategies to combat what Iton terms “the constellation of forces that conspire to deprive people of those critical resources that they need for health.” These include lack of education, housing, jobs, and recreation, and also the risk factors that tend to congregate in the same areas: crime, fast food, alcohol, drugs, and policies around policing. “I think that the environment, physical and social, drives a lot of the behavioral choices that people can make,” Iton says. “And I think changing the environments is critical.”

The department has set up some small “laboratories” in East Oakland, West Oakland, and Hayward, where public health workers go to every household, talk to people and invite them to participate in leadership and organized events. The program’s goal is to organize people and build social, political, and economic power among populations that don’t traditionally have that power. The program has been going on for about five years, and the results have been very promising. “We’ve found from the baseline to the first survey that we’ve substantially increased people’s sense of civic engagement, which you can walk your way back from that. We’re now trying to manage our way with that as a given—that profit-taking will be a core part of our health care system.”

Yet Iton remains optimistic about our ability to achieve quality health care in this country. He says, “People compare health care to a three-legged stool, with quality, access, and cost as the three legs. And there are some cynics that say you can have any two of those, but you can’t have all three. And I think they’re wrong. Because I think all three of those things are synergistic.”

---

“I wake up each morning trying to figure out ways to make one and a half million people healthier today than they were yesterday.” — Tony Iton

---

The Common Goal: Progress

Local efforts are a good reminder that it’s important not to lose sight of the true goals of health care reform, and that any movement is progress. “Often we spend so much time arguing over the details of the reforms,” says Dow, “that we lose the big picture of what the overall benefits would be to choosing one and moving it forward.”

Dow continues, “When we think about the health of the public, insurance reforms by themselves aren’t sufficient to have major impacts at a population level. People talk about the United States having worse life expectancy than a lot of European countries. My perspective is that it has very little to do with insurance systems. It has to do with the broader fabric of our society.”

Iton agrees and paints a grim picture of the state of U.S. health care: “In this country, we’ve sold out health care to the private sector. And I don’t think...