Health Care Reform: Why? What? When?
What it might take to effect comprehensive change.

by Victor R. Fuchs and Ezekiel J. Emanuel

ABSTRACT: Dissatisfaction with the U.S. health care system is widespread, but no consensus has emerged as to how to reform it. The principal methods of finance—employer-based insurance, means-tested insurance, and Medicare—are deeply and irreparably flawed. Policymakers confront two fundamental questions: Should reform be incremental or comprehensive? And should priority be given to reforming the financing system or to improving organization and delivery? We consider here several proposals for incremental reform and three for comprehensive reform: individual mandates with subsidies, single payer, and universal vouchers. Over the long term, reform is likely to come in response to a major war, depression, or large-scale civil unrest.

Changes are Necessary, but what they Ought to be, what they will be, and how, and when to be produced are arduous questions.
—John Jay (1787)

These words, written on the eve of the Constitutional Convention, aptly describe U.S. health care in 2005. Most observers agree that reform is necessary, but whether that reform should be incremental or comprehensive and whether changes in finance or changes in organization and delivery should receive priority are questions that must be answered. What are the options before the country? What are the obstacles to reform? What are the conditions that might make reform possible? Before addressing these questions, however, it is useful to review briefly why reform deserves urgent attention.

Why The United States Needs Health Care Reform

The palpable symptoms of our “sick health care system” are described almost daily in popular print and broadcast media. Almost one of every six Americans have no health insurance, health care spending is escalating rapidly, administrative costs are excessive, and medical errors (including overuse and underuse of medications and procedures) are rampant. Less frequently discussed, but of fun-
damental importance, are systemic problems in the financing of health care and in
the organization and delivery of care. Not discussed in this paper, because of space
limitations and because their relation to health care is usually indirect, are many
problems that affect population health, such as cigarette smoking, diet, exercise,
air pollution, and road safety.

Health care finance. Employer-based insurance. Ever since World War II, the
cornerstone of U.S. health care finance has been employer-based insurance. Today
such insurance still covers approximately 55 percent of the population, but with de-
clining coverage and loss of community rating, its role as quasi-social insurance has
greatly eroded in recent decades. Competitive pressures on U.S. firms have increased
as a result of antitrust actions, deregulation of many industries, and the inroads of
foreign competition. Many fewer U.S. firms now enjoy steady monopoly profits that
they can draw on to subsidize health insurance for their workers.

For example, forty years ago the largest private employer was AT&T, a regu-
lated monopoly with guaranteed profits. If health insurance premiums rose, they
could easily be passed on to telephone subscribers. Moreover, AT&T was under no
pressure to force older and sicker workers to pay more than their peers to compen-
sate for their higher use of care. Today the largest private employer is Wal-Mart,
which despite its size faces intense competition daily from a host of other retail
outlets. When they offer health insurance, it must come out of their workers'wages; for minimum-wage employees, this is not possible, so it often will mean
loss of jobs.

The decline of unions to about one in twelve private-sector workers has also re-
duced the role of employer-based insurance as quasi-social insurance.1 In indus-
tries comprising many small firms, such as residential construction, strong unions
organize industrywide labor-management health insurance plans, which typi-
cally allow for sizable cross-subsidies among firms and among individual employ-
ees within firms. In the past, tens of millions of workers were insured through
such plans, but the disappearance of unions from most of the private sector tends
to diminish the importance of this type of coverage.

Today most beneficiaries of employer-based insurance are in plans in which the
firms are self-insured or are experience-rated (which means that they are self-
insured with a year lag). Community-rated premiums have disappeared, thus
eliminating cross-subsidies among firms and industries, and the move toward
large deductibles and health savings accounts (HSAs) will reduce cross-subsidies
among workers within individual firms.4

Employer-based insurance involves high administrative costs for the more than
1,000 insurance companies seeking contracts with millions of employers and for
providers seeking reimbursement. Moreover, the large costs incurred by employ-
ers when negotiating contracts and administering benefits do not appear in the
health care spending estimates. Employer-based insurance has other serious
flaws: It distorts the labor-market decisions of workers and firms; it generates dis-
continuities in coverage; and, because premiums are exempt from income taxes, it provides a greater subsidy for high-wage than for low-wage workers.5

Means-tested insurance. Since 1965 the financing system based on employer-based insurance has been shored up by means-tested insurance, such as Medicaid, and by Medicare. These programs, which together cover almost 30 percent of the population, are also deeply flawed, but for different reasons. Means-tested insurance requires costly determination of eligibility, imposes high marginal tax rates on recipients because the subsidies fall or disappear as income rises, encourages evasion of reported income, and generates discontinuities of coverage as recipients move into and out of eligibility.6 State governments, which share in the cost of these federally mandated programs, are finding it increasingly difficult to fund them. As a result, education and other state programs face budget cuts at a time when they need increases.

Medicare is popular with most beneficiaries and with many physicians and hospitals, but it has two big flaws. On the benefit side, it is an open-ended entitlement that does not consider the costs of technologies relative to their benefits. Reimbursement of physicians by fee-for-service also contributes to escalating expenditures. Medicare expenditures are difficult to predict or control. For example, from 2003 to 2004 the bill for physician services jumped 15 percent. According to Medicare analysts, this was the result of longer and more intensive office visits, more laboratory tests, more frequent and complex imaging procedures, and greater use of in-office prescription drugs.7 With implementation of the new drug benefit in 2006, Medicare alone will consume 3.3 percent of U.S. gross domestic product (GDP) (7.5 percent in 2035), and the Medicare Hospital Insurance Trust Fund is predicted to be depleted by 2019.8 Short of massive increases in taxes or a slowdown in spending growth, Medicare is headed for financial failure.

Organization and delivery of care. Lack of IT. In addition to and in part because of flaws in the financing system, there are serious problems with the way medical care is organized and delivered. More than half of all physicians are in small practices; thus, they are poorly positioned to take advantage of advances such as information technology (IT), which could contribute to more efficient and effective care. Although large organizations such as the Palo Alto Medical Foundation have transformed their records system (without government subsidy), to the benefit of their patients, physicians, and the organization, for many physicians in small practices, the cost of electronic medical records (EMRs) outweigh their benefits.

Quality control. Inadequate quality control is another problem. Although there are frequent statements of concern about quality, Donald Berwick, a leading expert, recently expressed frustration with the slow progress that has been made.9 A critical examination of research on methods of quality improvement points out that even though “quality problems are widespread...reasons for these problems remain unclear.”10 The authors of this statement, Kaveh Shojania and Jeremy Grimshaw, suggest several possible explanations: Providers may not know what
experts recommend; they may know but disagree with the experts; the support systems needed to comply with the recommendations may be absent; or financial incentives may be misaligned. As has been observed in many contexts, it is difficult to get people to understand something when their income depends on their not understanding it.

Cost-benefit trade-offs. Another major problem with care organization and delivery is insufficient attention to benefit-cost trade-offs. Most physicians are conscientious about evaluating the benefits versus the risks of any intervention, but many fewer will consider costs, except perhaps for uninsured patients. Physicians often do not know what the costs are; they may believe that their responsibility is to deliver the best care that is technically possible, regardless of costs; or as Shojania and Grimshaw write, “Financial incentives may be misaligned.” Over the years, there has been a plethora of recommendations as to how physicians can contribute to more cost-effective care, but the fact that they have not been implemented on a wide scale suggests that the problem is systemic in nature. Some experts advocate a complete overhaul of the financing of health care to give physicians the information, opportunity, and incentive to deliver cost-effective care.

What Kind Of Reform?

Policymakers seeking to reform health care face two fundamental questions: Should reform be incremental or comprehensive? And should reform focus first on the financing of care or on the organization and delivery of care?

Incremental reform. Employer mandates. Most incremental reform proposals focus on financing—in particular, on reducing the number of uninsured people. Some reformers seek to increase coverage by mandating that all employers above some specified size offer their workers health insurance; these mandates may or may not be accompanied by subsidies or tax credits to the firms. One economic rationale for employer mandates is that the cost of care for uninsured workers is often passed along to the insured through taxes and other mechanisms. Mandates are, in part, an attempt to eliminate “free riders.” Their possible negative effects include loss of employment, especially for workers who are at or near the minimum wage, which makes it impossible for firms to pass on the costs by reducing wages. Firms that are below the specified minimum size that trigger the mandate could be discouraged from expanding or could resort to using more part-time or temporary workers to escape the mandate. When mandates are legislated at the state rather than the federal level, firms have an incentive to move to a state that does not have a mandate, even though economic efficiency would be greater in their original location.

Subsidies. Another incremental approach would provide subsidies for the uninsured, usually through tax credits, to purchase insurance in the individual market. The main advantage claimed for this approach is that it increases freedom of choice and does not intrude directly on the labor market. It could have indirect effects such as reducing the numbers of workers covered by employers.
are geared to income, there are the additional disadvantages associated with determining eligibility and disincentives imposed on people who might increase their income.

**Medicare and Medicaid.** Two other approaches for reducing the number of uninsured people are to build on the Medicaid and Medicare programs. For Medicaid, this would involve raising the income level for eligibility; for Medicare, it would involve lowering the age for eligibility. Expansion of these programs would magnify their existing advantages and their disadvantages. In addition, if nonpoor, working-age people become eligible for these public programs, there would probably be a decline in the number covered by employer-based insurance and even some decline in labor-force participation.

**Health savings accounts.** Some incremental reform proposals have objectives other than reducing the number of uninsured people. Consumer-directed health care, subsidized by favorable tax treatment of HSAs, aims at making patients more cost-conscious, leading to usage reductions and possibly more price competition among providers. It is also said that if costs to individuals vary with use, they will have an incentive to choose healthier behavior, such as stopping cigarette smoking. Out-of-pocket payments do give patients an incentive to use less care; whether they are able to make appropriate choices is much more doubtful. The RAND Health Insurance Experiment showed that patients with a higher percentage of out-of-pocket expense use less care, but the proportion of care that experts deem “appropriate” did not vary with the extent of insurance coverage.

There are several reasons for thinking that HSAs, or large deductibles in general, would not have as favorable an effect on utilization as advocates claim. First, a large fraction of health spending is accounted for by a small proportion of patients—patients whose spending levels will be far above their deductible. Second, even for those who have not yet exceeded their deductible but expect to do so before the end of the year, any particular test, visit, or procedure will effectively be free because the patient’s total outlay (the deductible) would be the same, regardless of whether or not they get the particular service. Third, a considerable amount of care is elective with respect to timing. People who have exceeded their deductible have a great incentive to undergo in the same year all of the tests and other procedures that they are contemplating because there will be no cost to them. Finally, a deductible that might be reasonable for a high-wage worker would be unreasonable for one making much less. Thus, there will be pressure to have the deductible vary with income, and that will give rise to other problems, including increasing the administrative costs of such plans.

**Managed competition.** Managed competition is another incremental reform proposal. Although in principle it can be applied to all health coverage, in recent years it has been aimed primarily at improving the efficiency of employer-based insurance. The leading proponent of managed competition, Alain Enthoven, believed that employers would see its advantages and voluntarily adopt it. Some have, but
most have not.19 As a result, Enthoven now favors legislation that would require every employer that offers insurance to offer a choice of plans. In addition, only the value of the premium of the low-cost plan could be counted as tax-exempt income by the employee.20 Those who choose more expensive plans would have to treat the excess as taxable income. In this approach, employees would have more incentive to choose the low-cost plan, and expensive plans would have an incentive to bring costs down to retain their customers. Some economists have raised theoretical objections to having employees pay the marginal difference between the cost of their plan and the low-cost plan, but their approach requires those workers in a firm who expect to use less care to subsidize those who expect to use more.21 In competitive markets, this cross-subsidization could not persist in the long run.

Quality incentives. Two other incremental reform proposals that work through financial incentives are paying for performance and subsidizing providers to install EMRs.22 The first assumes that public and private payers will be able to distinguish quality differentials among providers. Making such distinctions for such a complex, multidimensional service as medical care is not easy. Quality assessment might be forced to rely on a few relatively easy-to-observe “dos and don’ts” rather than on long-term outcomes. If payers decide to reward X at the expense of Y and Z, it does not take advanced study in economics to know that there will be some reallocation of time and other resources to X, even though patients might put as high a value on Y and Z. The British National Health Service (NHS) has had for many years a rating system for hospitals based on how well each hospital conformed to process specifications laid down by the NHS central administration. An independent study of British hospitals, however, found very little correlation between the NHS ratings and patient outcomes.23

Subsidizing providers to install EMRs will work in the sense that if the subsidy is large enough, some providers will surely take advantage of it. However, one may question whether such subsidies are a good use of scarce public funds. Many large health care organizations have already installed or are in the process of installing EMRs without subsidies. The holdup in small-scale practices might be not the oft-cited “lack of capital” but the much smaller benefit yielded by EMRs in such practices. Subsidies for EMRs will not change that economic reality. David Brailer, the national coordinator for health information technology, said, “Technology alone is never a lasting solution. The way health information technology is developed, the way it is implemented and the way it is used are what matter.”24 In short, EMRs might or might not be cost-effective, depending on the setting.

Comprehensive reform. A common goal of all comprehensive reform proposals is universal coverage, providing every American with health insurance. The proposals differ in how extensive the change from the current system would need to be, how providers of care would be reimbursed, and how money would be raised to fund the system. Here we consider three approaches to comprehensive reform; other approaches are typically variants or combinations of these three.
Personal mandates and subsidies. The proposal that would make the least change in the existing system is mandating that every American have health insurance that meets some minimum standard and having the government provide income-related subsidies or tax credits to the poor and near-poor to enable them to purchase insurance in the individual market or through exchanges formed for that purpose. In most versions, recipients of employer-based insurance would satisfy the mandate, as would Medicare beneficiaries. One version of the individual-mandate approach envisages the elimination of employer-based and means-tested insurance and the phasing out of Medicare. All Americans would be required to purchase one of three levels of coverage with income-related subsidies.

The fact that mandates with subsidies would build on existing systems of finance, organization, and delivery is perceived as an advantage by some and as a disadvantage by others. The advantage lies in simplicity of plan design and the likelihood that no large groups would believe that they had been hurt by the reform. The disadvantage is that this would preserve the existing methods of finance with all of their flaws and do little to increase the efficiency and effectiveness of the organization and delivery of care. Without increased efficiency, overall health spending would be likely to shoot up. For instance, Jeanne Lambrew and colleagues estimate that their reform proposal would require $100–$160 billion per year.

Mandates with subsidies seem relatively simple, but implementation could prove to be complex and expensive. Enforcement of a mandate on 300 million Americans would not be trivial, as evidenced by widespread noncompliance with liability insurance mandates by millions of automobile owners. What will happen when a patient who does not have health insurance shows up at a hospital with a heart attack or after a bad accident? Administration of income-related subsidies is also likely to prove problematic. Should a person’s subsidy be determined by income during the previous year or in the current year? If the latter, the appropriate subsidy would not be known until the year was over. If the former, the subsidy might be too large or too small, given the person’s current circumstances. With premiums now close to $10,000 per year for decent family coverage, the subsidies for low-income families would have to be substantial. Potential loss of subsidy would discourage efforts to increase income and encourage misreporting.

Mandates with subsidies would not require huge additional governmental outlays if everyone who now has insurance kept it. But that outcome is not certain. Low-income workers who now have employer coverage might find that it is economically advantageous to accept the subsidy while taking a better-paying job in a firm that does not offer coverage. Some might refer to this as an “unintended” consequence, but when there is evidence that substitution between private and public insurance does occur, it can hardly be considered “unforeseen.”

Single-payer proposals. Single-payer proposals come in several different versions; probably the best-known is the plan laid out by the Physicians Working Group...
The simplest way to think of this proposal is to imagine Medicare extended to cover all age groups. However, the PWG proposal goes beyond that simple version to cover dental services, long-term care, prescription drugs, and more comprehensive mental health care. Private health insurance would be sharply restricted or eliminated entirely. For-profit hospitals and clinics would be phased out over time. Copayments and deductibles would be eliminated or held to a minimum. Hospitals would be funded by an annual budget, fixed in advance. Physicians would be reimbursed by fee-for-service or salary. The global budget for the national health insurance program would be set at approximately the same proportion of GDP as in the year preceding its establishment. The PWG proposal suggests that funding could come from a variety of sources, including earmarked income taxes, payroll taxes, or compulsory employer contributions. For the long run, the PWG favors “income or other progressive taxes” as being “fairest.”

Some of the advantages claimed for a single-payer approach are supported by the experience of similar systems in other countries. It is the simplest, most straightforward way of achieving universal coverage. Administrative costs would undoubtedly be much lower than they are now, although it is a mistake to think that low administrative costs are always conducive to low overall costs. Much depends on the effects of less administration on the level of fraud and abuse. In Canada, most provinces do not report high levels of fraud, but in the United States, considerable fraud in Medicare is probably attributable, at least in part, to the desire to keep administrative costs low.

Experience in other countries also alerts us to some of the problems encountered in single-payer systems. For example, negotiated fee schedules have proved to be inadequate as a method of controlling spending in Canada because many physicians responded to what they regarded as inadequate compensation by ramping up utilization. Thus, Canadian plans felt obliged to respond by imposing caps on the annual compensation that each physician could receive. Fixed budgets for hospitals with capital outlays controlled by central authorities have been used by the British NHS since its inception but are increasingly found to be unsatisfactory. The NHS’s new reform efforts include freeing up hospitals to make their own decisions with regard to operations, including the ability to go to private capital markets for funds to expand or acquire costly equipment.

On paper, there is a strong egalitarian ethos in most single-payer plans, abundantly evident in the PWG proposal. In practice, however, many countries with such plans that are egalitarian on paper are less so in reality. Some patients and physicians make their own arrangements for care, with patients paying out of pocket or with private insurance. The physicians keep most or all of the proceeds as a supplement to their earnings in the national system. British specialists, especially surgeons, are so attached to their private earnings that when the NHS offered them a substantial boost in pay if they would agree to more accountability as to how they spend their time, they refused the contract. Even Canada, which has
the most egalitarian rules of any country, does not bar patients from obtaining care in the United States at their own expense. Moreover, it cannot prevent huge socio-economic differences in the use of some services such as magnetic resonance imaging (MRI) scans within a single city.33

Voucher system. The most recent proposal for comprehensive reform is based on universal health care vouchers (UHVs). This approach, which we favor, combines publicly funded social insurance for basic care with important elements of choice and competition.34 The central feature of this plan is universal coverage for basic health services, with guaranteed enrollment and renewal for the risk-adjusted value of the voucher. Individuals and families would have free choice of plans and freedom to purchase additional services with their own after-tax dollars. The voucher plan would be funded by an earmarked value-added tax (VAT). The proposal contemplates the end of employer-based insurance, elimination of Medicaid and other means-tested programs, and, over time, the replacement of Medicare. Administration and oversight, including selecting qualified plans, would be the responsibility of a federal health system, modeled on the structure of the Federal Reserve system, with regional boards to manage and oversee the various geographic regions. An independent Institute for Technology and Outcomes Assessment would be established and funded by a dedicated portion of the VAT.

The advantages claimed for the UHV approach are that every American would be covered for basic care without means-testing or exclusion for any reason; the financial burden would be distributed fairly according to a person's consumption; and, for the public as a whole, there would be a direct connection between the level of benefits and the level of taxes. Labor markets would work more efficiently because neither workers nor firms would base their decisions on extraneous health insurance considerations, and a major source of management-labor friction would be eliminated. State governments would be relieved of the large financial and administrative burdens associated with the means-tested programs. Because the proposed voucher system would provide basic care for all with freedom to choose among competing plans and freedom to purchase more than the basic care, it is more congruent with fundamental American values than single-payer proposals that emphasize equality or HSAs that emphasize freedom.

The voucher proposal does not contemplate legislation aimed at the insurance industry; however, because only a relatively small number of plans would be qualified to enroll beneficiaries under the voucher system, most of the more than 1,000 health insurance companies would disappear. Similarly, UHV proponents do not advocate legislation to change the organization and delivery of care, but they believe that if most people get most of their care most of the time from plans that are reimbursed by risk-adjusted capitation, changes in organization and delivery would inevitably follow. Of the three major approaches to universal coverage, UHV is the one most likely to precipitate changes in organization and delivery as a result of the capitation reimbursement.
Compared with other comprehensive reform approaches, several questions are specific to or more pronounced with the UHV approach. How would health plans qualify to participate? What kind of reimbursement system would reward efficiency and cost-effective care without creating incentives for stinting and adverse selection? How quickly and successfully would the major health plans adapt to risk-adjusted capitation reimbursement? What arrangements would be made for care in rural areas and small towns where low population density precludes the presence of several competing plans? Perhaps most important, because the UHV approach contemplates more far-reaching changes in the health care system, how would the transition from the existing system be handled?

In addition, UHV, like any comprehensive reform, would have to address several difficult questions. How to specify the universal benefit? What arrangements would be permitted for care beyond the universal benefit? How would the wide geographic disparities in use and spending documented by John Wennberg and others be dealt with? How would disputes about coverage and malpractice be handled? How would funding for research and education be provided?

Exhibit 1 provides a succinct summary of the principal features of alternative reform proposals, and Exhibit 2 shows the relation between the goals of reform and the alternative proposals.

**Incremental versus comprehensive reform.** Advocates of incremental reforms acknowledge that they are less-than-optimal public policy. Incremental reforms will not achieve universal coverage, greatly reduce administrative expenses, or address discontinuities in coverage, and they are not likely to greatly increase the cost-effectiveness of care. The principal virtue claimed for incremental reforms is their political viability: “Limiting the restructuring of the health care system may improve the political prospects” of enactment.

What has incremental reform achieved? Over the past decade, it has led to the State Children’s Health Insurance Program (SCHIP) and expanded drug coverage for Medicare beneficiaries. Yet today we have an ever-declining proportion of people with employer-based insurance; more people uninsured than at any time since 1998, including more than 8.4 million uninsured children; and record-high and rising health care costs. Taken as an overall strategy, there is little evidence that incremental reform has improved U.S. health care. Also, given the current concerns about costs, adoption of new incremental reforms seems unlikely because any increase in coverage through incremental reform will result in greater health care spending. For example, to cover an additional twenty-seven million people, the proposal by presidential candidate John Kerry would have required $653 billion over ten years; President Bush’s more modest plan would have covered just 2.4 million uninsured Americans at a cost of $90 billion over ten years. Political viability requires a plan to transform the inefficiencies of the current system into expanded coverage without increasing total outlays for health care.

**Reform priorities: finance or organization?** Which should take priority: re-
The experience of the past forty years shows that without major changes in finance, past efforts to improve organization and delivery have not had widespread success, despite good results in particular settings such as the Veterans Affairs (VA) system, the Palo Alto Medical Clinic, and the Kaiser Permanente system. These large organizations are in an excellent position to take advantage of drug formularies, EMRs, physician extenders, and other innovations that improve patient care while reducing costs. The current cost-insensitive delivery system did not descend from heaven. It is a response to numerous forces and incentives—financial, peer approval, accreditation, government regulation, and others. The history of previous attempts to reform health care should serve as a warning that we cannot rely on exhortation to change physicians’ and hospitals’ behavior. Tangible incentives will be required to get physicians and hospitals to change their practice patterns. Although finance re-
## EXHIBIT 2
Relation Between Goals Of Reform And Alternative Proposals

<table>
<thead>
<tr>
<th>Reform goal</th>
<th>Incremental change</th>
<th>Individual mandates with subsidies</th>
<th>Single payer</th>
<th>Universal health care vouchers (UHVs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal coverage</td>
<td>Reduces number of uninsured but does not achieve universal coverage</td>
<td>Achieves universal coverage</td>
<td>Achieves universal coverage</td>
<td>Achieves universal coverage</td>
</tr>
<tr>
<td>Cost-effective care</td>
<td>Some proposals seek cost-effectiveness; most do not</td>
<td>No major change</td>
<td>Controls spending through negotiations with providers and fixed budgets</td>
<td>Earmarking of value-added tax (VAT) to link benefits and willingness to pay taxes Purchase of additional services with after-tax dollars—that is, eliminates tax-deductibility of insurance Institute for Technology and Outcomes Assessment to change mix of technology introduced</td>
</tr>
<tr>
<td>Continuity of coverage</td>
<td>Retains current system with discontinuities from changes in employment status or jobs, or employers’ change in health plans</td>
<td>If retains employer-based insurance, does not reduce discontinuities</td>
<td>Complete continuity of coverage; some providers may decline to participate</td>
<td>Complete continuity since people stay in same plan as long as they wish regardless of changes in employment, health status, or other circumstances</td>
</tr>
<tr>
<td>Labor-market efficiency</td>
<td>Retains employer-based insurance that distorts employer and employee decisions about hiring, outsourcing, job changes, taking jobs with loss of Medicaid eligibility</td>
<td>If retains employer-based insurance, does not reduce labor-market distortions</td>
<td>Eliminates any connection between health coverage and employer/employee decisions</td>
<td>Eliminates any connection between health coverage and employer/employee decisions</td>
</tr>
<tr>
<td>Equitable and efficient subsidies</td>
<td>Tax treatment of employer-based insurance is retained and continues to provide greater subsidies to high-income and well-insured; some low-income workers are ineligible for state-supported programs</td>
<td>Unclear how subsidies and mandates will affect different groups; if tax treatment of employer-based insurance is retained, well-off benefit more; many low-income workers may have to pay a high proportion of income for coverage</td>
<td>Depends upon which taxes are used: payroll tax would place higher burden on lower-income people; income tax is nominally progressive, but loopholes allow high-income people to avoid payment</td>
<td>Users contribute to the basic package in proportion to their consumption of goods and services; poor and sick receive more care than they pay in taxes without explicit means testing</td>
</tr>
<tr>
<td>Administrative costs</td>
<td>Varies, but probably similar to current system</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ analysis.
form is certainly not a sufficient condition for major improvement in organization and delivery, it is probably a necessary one.

When? Prospects For Comprehensive Reform

Although prominent Republicans such as Senate Majority Leader Bill Frist and Rep. Bill Thomas, chairman of the House Ways and Means Committee, have said that the health system needs comprehensive reform, the short-run prospects for such legislation seem dim. Indeed, the political climate is so unfavorable that even modest incremental changes are not under serious consideration.

Obstacles to reform.

Satisfaction with status quo. There are numerous obstacles to comprehensive reform, not the least of which is that many individuals and organizations are satisfied with the status quo. Even if as much as two-thirds of the public were dissatisfied with the present system, that would leave a sizable minority who do not want any reform.

Single-issue groups. A second obstacle comes from single-issue constituencies. These groups want change in the system, but they each want different changes. Some press for better coverage for particular demographic groups; others want more attention and resources devoted to people with particular diseases; and still others press for more preventive care, more patient involvement in care, or more attention to the needs of rural areas. While often giving verbal support to comprehensive reform, single-issue constituencies tend to concentrate their lobbying efforts on their particular issues.

U.S. system of government. The U.S. system of government, with its checks and balances and divided responsibilities, constitutes another obstacle to comprehensive reform. The founding fathers deliberately set in place political institutions that are inherently resistant to radical change of any kind—economic, social, or political.

Any comprehensive change in the health care system is likely to result in winners and losers. Prospective losers are likely to be much more involved and effective in blocking change than prospective winners will be in promoting it. As Machiavelli, one of the shrewdest political analysts of all time, noted, “There is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order.” The challenge for reformers is to design mechanisms that will mitigate the unfavorable effects on potential losers while creating major gains for society as a whole.

Even those who are uncertain about how reform will affect them may oppose it because they are risk-averse. They may agree that there are problems with the current system with regard to cost or access or quality of care, or even all three, but at least the problems are known. Except in unusual times, most people prefer “the devil they know” to the one they don’t know.

Differences of opinion. Last, but not necessarily least, any particular reform pro-
posal must overcome resistance from those who favor comprehensive reform but differ strongly over the changes they would like to see enacted. These differences may arise because of analytical disagreements—the effect of alternative approaches on total spending, quality of care, or disparities in care—or because of differences in values—how egalitarian the system should be, how important is freedom of choice, and how large a share of the nation's resources should be devoted to health care.

Possible precipitators of reform. The foregoing list of obstacles to reform is so imposing that one might be tempted to think that comprehensive reform is impossible. But that would be a mistake. The prospects for changing the Articles of Confederation into a Constitution for a unified country seemed dim in 1787, as indicated by the quotation from John Jay at the beginning of this paper. The first meeting of the Constitutional Convention in Annapolis was quickly adjourned because of poor attendance. When it reconvened in Philadelphia, supporters of radical change had little hope of victory, but they succeeded, and even strong opponents came around to supporting the new Constitution. Or consider a sample of major social and economic changes that the United States has adopted over the past hundred years: the Federal Reserve System, Social Security, civil rights, and protection of the environment. Anyone analyzing the political climate in the decades preceding enactment would have difficulty finding evidence of widespread support for such momentous changes. But they did occur.

What might set the stage for comprehensive reform of health care? A major war, a depression, or large-scale civil unrest might well set in motion a change in the political climate that would overpower the obstacles that prevail in normal times. A national health crisis, such as a flu pandemic, might also light the fuse of change. Short of a major economic, social, political, or health crisis, there might be a confluence of forces that together would propel the nation toward comprehensive reform over the next decade, such as widespread dissatisfaction of the business community with employer-based insurance; state governments’ inability to sustain the ever-growing fiscal drain of federally mandated, means-tested insurance; or a financial crisis with Medicare. Leadership from the business community and states might together galvanize comprehensive reform. Finally, there might be a growing realization by average Americans that the risks of the current system to them personally and to the country as a whole outweigh the risks of comprehensive reform.

The authors gratefully acknowledge helpful comments from Alain Enthoven, Rob Cunningham, and three anonymous reviewers and financial support from the California HealthCare Foundation and the Robert Wood Johnson Foundation.
NOTES
11. Ibid.
20. Personal communication to Victor Fuchs from Alain Enthoven, June 2005.
100.

27. L.W. Haase, How to Cover Everyone and Get Medical Costs under Control (New York: Century Foundation Press, 2005).


35. J.E. Wennberg et al., “Use of Medicare Claims Data to Monitor Provider-Specific Performance among Patients with Severe Chronic Illness,” Health Affairs, 7 October 2004, content.healthaffairs.org/cgi/content/abstract/hlthaff.var.5 (16 August 2005); and V.R. Fuchs, “More Variation in Use of Care, More Flat-of-the-Curve Medicine,” Health Affairs, 7 October 2004, content.healthaffairs.org/cgi/content/abstract/hlthaff.var.104 (16 August 2005).


40. Ibid.


44. N. Machiavelli, The Prince and The Discourses, ed. M. Lerner (New York: Modern Library, 1940), 21. (The Prince was first published in 1532; The Discourses, c. 1517.)

45. Pauly, “Conflict and Compromise.”