Seven Provocative Principles for Health Care Reform

C. David Naylor, MD, DPhil
Karline Treurnicht Naylor, BSc

HEALTH CARE MANAGERS ACROSS INDUSTRIALIZED NAtions have embraced innovations such as modernized information systems, improved integration of services, and better design of financial incentives. However, debate about "big picture" policy remains highly polarized. That observation is underscored in the United States by political responses and legal challenges to the 2010 Patient Protection and Affordable Care Act (ACA). Meanwhile, north of the border, there is renewed controversy regarding the public financing of Canada's provincial single-payer health plans.

This Viewpoint accordingly sets out 7 principles for broad health care reform, with particular reference to the US and Canadian health care systems.

Seven Principles of Health Reform

There is no perfect health care system. Every set of national arrangements involves tradeoffs among quality, affordability, and accessibility. In 2009, health expenditures totaled 11.4% of gross domestic product in Canada and 17.4% in the United States. Health care spending, however, has little correlation with citizen satisfaction. Indeed, multiple surveys sponsored by the Commonwealth Fund[1,2] show that substantial numbers of citizens and primary care physicians in many countries are frustrated with their health care systems,[3] and citizens everywhere have some appetite for reform.

Although overall health care systems are not transplantable, the merits of adopting good ideas from other countries are too often ignored. There is no one-size-fits-all health care system. Each nation develops arrangements that conform to its historical, economic, and social circumstances. Nonetheless, "best practices" from other jurisdictions are often worth trying on a piecemeal basis. However, some Canadian commentators caricature US health care, ignoring examples of superb clinical care, integrated delivery systems, pioneering quality management, and advanced use of information technology. Conversely, US critics of "Obamacare" demonize Canadian health care as a Soviet-style nightmare. In fact, Canadian hospitals by and large are private, nonprofit corporations, and most physicians work as private practitioners in solo or group arrangements. Governments intercede primarily by pulling broad fiscal levers, with limited micromanagement. The fear of Canadian contamination of the US system is particularly ironic, given that the ACA does not even include a public option.

Simplicity in legislation and regulation trumps complexity. The more changes that are made concurrently, the greater the risk of unintended consequences. In clinical practice, changing too many things at once leads to unintended consequences as well as confusion about causes and effects. This insight is also applicable in public policy.

Canada's 2 cornerstone pieces of health care legislation, passed in 1957 and 1966, comprise about 14 pages. After observing provincial experiments with single-payer coverage, the federal government proceeded in 2 stages with simple laws that achieved national coverage by conditional cost-sharing with any qualifying province. In contrast, the ACA alone totals 906 pages. The act contains many positive provisions, eg, extension of coverage to all; measures to promote innovation and integration in service delivery; funding for applied research; and support for wider adoption of electronic records. However, its reach and complexity are overwhelming. In brief, the ACA may at once be too big to fail and too big to succeed.

Every efficient health care system imposes caps on spending and engages in strategic rationing. In general, systems with universal coverage contain costs by empowering a single payer or regulator to control the overall outflow of funds. This approach alleviates the need for micromanagement of clinical decisions but does leave clinicians and hospitals with the challenging mandate of allocating scarce resources. On the other hand, the new US legislation creates a complex system of entitlements involving not just individuals and families but a variety of public and investor-owned intermediaries.

Spending caps do mean that Canada and other nations tend to ration care by availability, with queuing based on first-come-first-served or clinical need. Conversely, the US system essentially rations care by income, education, and insurance.

Fairness in finance and access to health care is an evergreen objective of health policy makers. However, fairness is seldom defined. As occurred in Canada, universal coverage in the United States can ameliorate income- and

Author Affiliations: Department of Medicine, University of Toronto, Toronto, Ontario, Canada (Dr Naylor). Ms Treurnicht Naylor is a student in the MPH program at Columbia University, New York, New York, and a medical student at The University of Western Ontario, London.
Corresponding Author: C. David Naylor, MD, DPhil, University of Toronto, 27 King's College Cir, Ste 206, Toronto, ON M5S 1A5, Canada (david.naylor@utoronto.ca).

insurance-related differentials in access to health care. However, some data suggest that lower-income US residents already have better access to care than high-income earners in many other countries with universal coverage.[1] Researchers also have confirmed that socioeconomic disparities in service utilization and, importantly, in health status stubbornly persist, even in highly egalitarian systems. Thus, from the standpoint of fairness, investing in social programs targeting the disadvantaged may ultimately do more to reduce health disparities than spending tax dollars to subsidize sickness care for the middle class.

Higher levels of spending do not correlate closely with quality of care but may instead lead to diminishing marginal health benefits. Over the course of many years, researchers in the United States and Canada have studied variations in clinical care, drawing many cross-border comparisons. Higher spending in the United States correlates with more technologically intensive care in predictable ways. Otherwise, the literature shows no consistent relationship between levels of spending and good or bad clinical decisions, although, in some cases, researchers do report an inverse correlation between resource consumption and the marginal health benefits of interventions. The law of diminishing marginal returns applies to most areas of human endeavor, and there is no reason why health care should be an exception to this tenet.[4]

This last observation underscores the potential effectiveness of what Mechanic[5] called "implicit rationing" by clinicians when resources are constrained. It helps explain why substantial increases in health care spending do so little to improve overall population health statistics and also underscores the importance of defining fairness. At risk of oversimplification, it seems the US definition of health care fairness presumes that wealthier citizens should have an inalienable right to choose to spend more, even if the marginal yields are trivial. The Canadian definition presumes that individual citizens do not have that right, even if the marginal yields are meaningful.

Transactional micromanagement of health care is suboptimal, whether publicly or privately administered. Administrative costs of health care in the United States are far higher than in Canada, a difference only partly attributable to the plethora of payers in the United States. Whereas many nations, including Canada, give clinicians substantial autonomy to allocate constrained resources, the United States has built a massive industry based on micromanaging clinical care to contain costs.[6] Clinical leadership in quality management is vital to limit this unhelpful trend.[7] However, until and unless prepayment mechanisms are established that make spending more predictable, public and private payers alike will be drawn to micromanagerial measures.

Reflections and Directions

Health care in the United States combines unmatched peaks of excellence with high overall spending, global leadership in health-related research, and persistent cost-related barriers to access. With exemplars such as the Veterans Administration system or the Kaiser-Permanente prepayment model, the United States has also demonstrated organizational innovations aimed at integrating care, aligning incentives, and using information technology in a highly strategic way. Broadly speaking, however, the United States lags on a wide array of health care and health status indicators. It is particularly baffling that the US government still has not initiated health care tort reform—arguably the simplest and fastest way to cut waste and improve physician morale. Meanwhile, the fate of the ACA hangs in the balance, awaiting decisions to be rendered both by the Supreme Court and by voters in the 2012 presidential election.

Canada's health care model offers the cost advantages of single-payer administration and features universal first-dollar coverage for a wide variety of services. Health care and health indicators are near the average for peer nations. Canadian "Medicare" has achieved iconic status as a program that differentiates Canada from its neighbor to the south, but the structure of health care has evolved surprisingly little since the 1970s. Canada is therefore at risk of becoming the "frozen north" of health care delivery. Survey data also highlight public frustration with problems accessing a range of specialty services, although spending on health care now consumes more than 40% of provincial budgets.

In sum, although this Viewpoint presents some general principles, there are no policy panaceas for health care in Canada, the United States, or any other industrialized nation. It nonetheless remains conceivable that Canada's single-payer systems will migrate toward more pluralistic arrangements as exist in Europe, even as the US funding system evolves from its current chaotic complexity to a more coherent, simplified, and equitable structure. The result may be that health care, far from differentiating nations that are fast friends and good neighbors, will emerge as yet another point of cross-border convergence.

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Naylor reported receiving support for travel to meetings and payment for lectures from the American College of Surgeons. No other disclosures were reported.
Previous Presentation: A version of this Viewpoint was presented as the Franklin H. Martin Memorial Lecture at the annual meeting of the American College of Surgeons; October 25, 2011; San Francisco, California.

REFERENCES

1. Schoen C, Osborn R, Squires D, Doty MM, Pierson R, Applebaum S. How health insurance design affects access to care and costs, by income, in eleven countries. *Health Aff (Millwood)*. 2010;29(12):2323-2334.
2. Schoen C, Osborn R, Squires D, Doty M, Pierson R, Applebaum S. New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated. *Health Aff (Millwood)*. 2011;30(12):2437-2448.
3. Schoen C, Osborn R, Doty MM, Squires D, Peugh J, Applebaum S. A survey of primary care physicians in eleven countries, 2009: perspectives on care, costs, and experiences. *Health Aff (Millwood)*. 2009;28(6):w1171-w1183.
4. Fuchs VR. More variation in use of care, more flat-of-the-curve medicine. *Health Aff (Millwood)*. 2004(suppl variation):var104-var107.
5. Mechanic D. Approaches to controlling the costs of medical care: short-range and long-range alternatives. *N Engl J Med*. 1978;298(5):249-254.
6. Grumbach K, Bodenheimer T. Reins or fences: a physician's view of cost containment. *Health Aff (Millwood)*. 1990;9(4):120-126.
7. Brook RH. The role of physicians in controlling medical care costs and reducing waste. *JAMA*. 2011;306(6):650-651.