Health Care Reform And The New Economy

Does the new digital economy require a different vision for health reform—its principles as well as its possibility?

by Paul Starr

ABSTRACT: The objectives and assumptions of health care reform have changed repeatedly during the past century and may now be entering a new historical phase as a result of the “new economy” rooted in information technology. In a high-growth context, proponents of reform may no longer feel obliged to bundle expanded coverage with tighter cost containment. At the same time, the new digital environment may facilitate innovations intended to inform and expand consumer choice and to improve quality. The new environment elevates “transparency” to a guiding principle. Health informatics has long been peripheral to reform and must now become more central.

Since the national debate about health care reform in the early 1990s, American society has changed far more than anyone expected in so short a time. The looming deficits, persistent inflation, relatively high unemployment, concomitant economic anxiety, and diffuse cultural foreboding are gone, at least for now. While the exceptional performance of recent years may prove ephemeral, the “new economy” rooted in information technology (IT) is not a transitory phenomenon. Fundamental changes in communications and society are in the making, and entire new industries are taking shape. During the second half of the 1990s the IT industries contributed nearly a third of economic growth and half or more of the acceleration in productivity growth, according to a recent Commerce Department analysis. Economic inequality has not abated; indeed, inequalities in wealth have risen sharply in the past two decades. However, with unemployment among blacks and Hispanics lower than at any time in recent history, the poor are also benefiting from the new economy—although their position is more precarious, especially given time limits in welfare reform, declining Medicaid enrollment, and the likelihood that they will be the first to lose their jobs in a recession.

How do these new circumstances affect health care reform? In the
early 1990s economic insecurities raised concerns about “health security,” while projected budget deficits and inflation focused attention on cost containment. The opponents of federal measures to achieve universal coverage had many of the same worries about jobs and the deficit, except that they thought the government would make the problems worse. Today’s easing of economic worries might be expected to facilitate consensual change, but the effects run in contrary directions. Rising surpluses make new expenditures more feasible, while prosperity takes some of the felt urgency out of reform. According to opinion polls, more Americans support using the surplus to expand health care than to cut taxes, but the new fiscal environment has not inspired a groundswell of interest in universal coverage.³

The Unbundling Of Reform

In one respect, however, the projected surplus has had a profound effect on health politics. The expansion of coverage is now being unbundled from the rationalization of the health care system. Proposals for what used to be called “compulsory” or “national” health insurance have undergone considerable evolution in defeat.⁴ The original measures introduced before World War I were as much concerned with providing cash payments during illness (sick pay) as with covering the costs of treatment, and they were chiefly aimed at helping urban workers. Reformers introduced the proposals at the state level, and that is where the battles were fought and lost. By the 1930s the focus had shifted to the costs of medical care, the debate had moved to the federal government, and coverage was conceived more broadly, although it was still not yet universal. From the New Deal through Truman’s national health insurance plan and the original Medicare legislation, reformers continued to assume that federally provided health insurance would mean channeling increased resources to health care and that this was a good and necessary thing.

By the 1970s, however, rising costs began to preoccupy health policy, and proposals for expanding coverage were increasingly conceived as a means of rationalizing the system and reducing its inefficiencies. It was in this context that the debate emerged between regulatory and market strategies. The Clinton health reform plan, which attempted a synthesis of those strategies, was, in a sense, the culmination of the “comprehensive” approach that tried to bundle the rationalization of the system and the expansion of coverage into one program. Because of the fiscal pressures that dominated policy making from the mid-1970s to the mid-1990s, aggressive cost containment seemed to be the necessary concomitant of coverage ex-
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Because business also was seeking new means of controlling the cost of health benefits, the comprehensive approach had the potential to bring together the business community with advocates of universal health insurance.

Now we are seeing further evolution in defeat as the political logic of the comprehensive approach unravels. The budget surplus opens up a politically more attractive path for financing, and the rise of managed care directly addresses the interest of business in containing its own costs. Loading stringent cost containment onto policies aimed at expanding coverage seems like taking on a lot of excess political baggage. In the 2000 presidential campaign Bill Bradley, Al Gore, and George W. Bush all made proposals to expand coverage, but none included new cost containment measures.

A politics focused on extending benefits invites compromise. If one party supports a program expansion and the other a tax credit, why not do some of both? In a highly toxic political environment this is unlikely, but in a milder climate with growing surpluses it seems quite possible. Such piecemeal measures might seem small but have long-run implications because they could become the basis of policy development in future administrations or by reform-minded states. The State Children’s Health Insurance Program (SCHIP), for all its limitations, may be a step toward public assumption of the health care costs for dependents of low- to moderate-income parents. That could reduce the magnitude of any future requirements for employer coverage and lay the groundwork for an employee-only mandate or, as I would prefer to conceive it, a health care minimum wage (an increase in the minimum wage earmarked for health benefits). Coverage of nonworking spouses could be addressed through a combination of tax credits and subsidized buys-ins to public or private insurance plans. Usually described as “incrementalism,” this approach might be more positively conceived as “sequentialism” (to borrow a term from Ron Pollack of Families USA).

The promised bounty of the new economy makes such a path imaginable; the persistent income inequality of the new economy may make it necessary. But does the new economy require any different vision of health reform? What are the implications, if any, of the information revolution and digital economy for the principles and mechanics of reform as well as its political feasibility? A great deal of health care commerce is migrating to the Internet. Should the
infrastructure of reform also migrate there? In this paper I organize my discussion around some of the principles of reform widely discussed in the 1993–1994 debate about the Clinton plan.

Choice

One of the paradoxes of the managed care revolution is that it has run in the opposite direction from other trends toward more individual choice in American society. A few decades ago most Americans had just one option for savings (a passbook savings account) and one option for telephone service; now we have a wide array of alternatives for financial services and telecommunications. Consider the increase in the size of new supermarkets and other retail stores and the expanded variety of products they carry. IT has facilitated this growth in “mass customization” and consumer choice, and the Internet and e-commerce are further extending that trend.

As organizations, health insurance plans are more diverse than they used to be, but that is not how consumers see the rise of managed care. Under the traditional fee-for-service system consumers enjoyed an unrestricted right to choose their providers. Not only do managed care plans constrain those choices; our system for purchasing coverage also limits the consumer’s ability to choose a plan. When most employers choose health plans today, they are effectively determining which doctors and hospitals their workers can use without paying out-of-plan rates. Indeed, as of 1999, 81 percent of covered employees in firms with 3 to 199 workers had no choice of plans whatsoever. This is an anomalous situation in an age when Americans reasonably expect to have more choices, not fewer.

Part of the answer to that anomaly is to give the choice of health plans to the individual employee. But how to do that in a system where employers cannot contract with all available plans? The managed competition proposals of the early 1990s envisioned a health insurance purchasing cooperative (HIPC) that would aggregate employee groups and enable individual employees to choose among the plans in an area. The Clinton plan called this mechanism a “regional health alliance” and required that at least three types of plans be offered: fee-for-service as well as health maintenance organization (HMO) and preferred provider organization (PPO). Some Republican proposals have called their voluntary versions of purchasing alliances “HealthMarts.”

New IT does not help overcome the obstacles to aggregating risk pools. It does, however, address the objection that these proposals would add another “layer” of bureaucracy. A HIPC, an alliance, or a HealthMart can now be conceived of as an electronic marketplace. Like e-commerce generally, it can cut out intermediaries—in this
case, in benefits offices—cheaply and conveniently disseminating information to consumers and relaying online enrollment decisions to plans.

To be sure, not everyone uses the Internet. According to Nielsen//NetRatings, the proportion of Americans as of March 2000 who were active users had quadrupled in five years but was still only about 30 percent (81.6 million people), although the share with online access was approaching 50 percent (129.7 million people). Online access at work, in public libraries, and at various commercial establishments is becoming easier for many of those still lacking access at home. An electronic market could become the site where a growing proportion of consumers make their annual enrollment choice and also find (or link to) data on consumer satisfaction and other relevant measures of performance. When employers provide such information, consumers do make use of it. One of the virtues of online technology is that it can put decision-making information together with the decision. It also can provide a way for members of plans to communicate with each other and compare experiences. Even if only a minority of consumers use the opportunities for better information and communication, they can help to sensitize health plans and providers to key cost and quality issues.

It is unclear whether the Internet will encourage wider choice of providers within plans, but it plainly encourages a stronger consumer role in choice of treatment because of the access it affords patients and their families to information about therapeutic options. No doubt some of the information on the Internet is unreliable; just as people have to learn to discriminate among printed sources, so they need to learn to read the Net for signals of trustworthiness. The recent growth of professionally written and edited consumer health sites is impressive, however, and for those who suffer from illnesses it is a positive advantage that much posted health information on the Net comes from people who share the same condition and have faced similar life choices. These growing lateral relationships among patients as well as the growth in online data tend to erode the exclusive professional control of knowledge about treatment alternatives that has long prevailed in medicine. Such developments help to reform the system, if reform means (as I believe it should) greater empowerment of patients and stronger checks and balances in health care.

Quality

Broadly speaking, quality has two dimensions: (1) the objective, technical aspects of care (the accuracy of diagnosis and effectiveness of treatment), and (2) service and patient satisfaction. Most of the
discussion about IT and quality has focused on the development of outcomes measures for improving the technical dimension of care. Presumably, as more health care activities become computer mediated, it should become cheaper to build databases; as more health care providers use electronic networks on a regular basis, broader collaboration in research should get easier, as it has in academe and the technology industries. New knowledge about outcomes should improve not only clinical judgment but also organizational processes, reducing mistakes and iatrogenic disease.

The impact of the digital revolution on customer service and patient satisfaction may be equally important. In other industries new information technology has improved service—for example, by making it easier and more convenient to perform transactions and providing quicker turnaround times on customer orders. As yet, health care itself has been little affected. Much consumer dissatisfaction with health care, however, stems from poor service. Improvements in other industries may have only accentuated patients’ irritation with the long waits and difficulties in getting questions answered in the health care system.

This has been the context for the spectacular growth in the use of the Internet for consumer health. Many patients and their families have turned to the Internet to get advice and information about health problems more quickly and to learn about options that their doctors or health plans might not otherwise provide. Most of this surge in communication occurred completely outside the mainstream health system; it was spontaneous, informal, and at first noncommercial. During the past two decades health information networks were developing on two separate tracks. The industry was preoccupied with building data networks to link hospitals and hospital suppliers, pharmaceutical wholesalers and retailers, and providers and insurers. Health care organizations invested heavily in enterprisewide networks to overcome the fragmentation of their own information systems, and some coalitions and alliances sought with limited success to extend these into community health information networks. But on a separate track that the industry hardly thought worth its attention, popular health communication on the Internet was exploding, and, ironically, this is turning out to be the basis of electronic health commerce. In effect, the “system” is coming to the “people” as health plans and providers establish Web sites and open up online avenues of communication with patients and each other. A variety of health care businesses on the Web now provide customized health information and medical advice and a widening array of services.

These developments may seem unrelated to reform; some critics
may say that they also are unrelated to quality because so much of the information on the Internet is unreliable. Today’s developments, however, are the first steps in a major reconfiguration of health care. Telemedicine has generally been thought of as an exotic service for such situations as emergency care in remote rural areas. But especially as the Internet turns to broadband access, a large part of the population will routinely consult providers via computer, using full video and data links, not just e-mail as we know it. Patients with chronic conditions may be continuously linked to the network, their conditions monitored by sensors and computers that they carry around as part of their clothing or themselves. The “physician visit” or “encounter” in the conventional sense may be an increasingly less relevant measure of a unit of medical care (this will make capitation even more logical than it is now). The Internet generally makes us less place-dependent—and that will increasingly be the case with health care.11

For some the development of these options may be an improvement in service. Customized health information services and electronic consultations may economize on people’s time—an efficiency that is not registered in any health statistics, although it is real enough to consumers. Other patients may never want to use online services and electronic consultations and prefer to pay for more personal, face-to-face counseling and care. In health care, as in other industries, one of the most important effects of the information revolution may be to provide a greater variety of service options. That widened array will be an improvement in quality if consumers have choice among them, but it will be viewed as a decline in quality if one option is imposed on them.

Cost, Affordability, And Innovation

Hoped-for savings from computerization have so often proved illusory that policy analysts are deservedly skeptical about claims that technology will make health care cheaper. Expenditures on health care will likely continue rising because technological innovation makes possible new services and products, but new technology can also blunt or offset some of this increased cost through improvements in productivity. Such improvements may come about in at least three ways. One is through the reduction of transaction costs, particularly the costs of business-to-business transactions where
e-commerce is generally showing the fastest growth. A second is through an increase in long-distance competition, which can help break up local monopolies; teleradiology, for example, can put radiology centers in distant cities in competition with local radiologists. A third is through the substitution of lower-cost alternative products and services, such as personalized, interactive online data services that replace professional consultations.

The full benefit of these developments hinges partly on public policy. The absence of shared standards for data communication has long limited savings in transaction costs. Even though the Health Insurance Portability and Accountability Act (HIPAA) of 1996 finally set in motion a national standard-setting process, progress has been painfully slow. The act deals only with administrative, not clinical, data; only one of nine administrative standards has yet reached a final rule making, and even that standard does not become effective until 2002. Nonetheless, thanks to the open architecture of the Internet, online medical services are taking off on the Web and achieving some of the objectives of data sharing that HIPAA is aimed at promoting.

Other obstacles in law and policy also stand in the way of greater efficiencies. The potential for long-distance competition is limited by state licensing laws that often make online consultations across state boundaries illegal. The substitution of lower-cost online alternatives to conventional products and services is limited by restrictions on public and private insurance reimbursement. Some regulatory measures intended to protect public health and privacy could inadvertently retard innovations in new technology.

Dwarfed by other issues, impediments to the digital economy in health care have been of little interest to health care reformers. However, if there is significant benefit in both quality and cost from computer networks and other new technology, reformers ought to make such issues a more central part of their agenda. Hardly anyone, for example, has wanted to take up the issue of state licensing as a barrier to competition, but if the Europeans can establish a continental system of licensing, why is it inconceivable that the United States can establish a national one? The current licensing system is a form of protectionism that ought now to be seen as interference with legitimate interstate commerce. It’s time to attack it head on.

**Simplicity And Transparency**

One criticism of the Clinton plan, even from its supporters, was that it was too complex, and its opponents ridiculed the proposal by quoting opaque sections of the legislation and holding up a diagram of its proposed architecture that looked like a Rube Goldberg con-
traption. Of course, the existing system is mystifyingly complex, and every serious health bill in Congress includes technical language that ordinary citizens (and even experts!) find incomprehensible. Reform should be simpler, but it can never be simple.

Incrementalism is itself a step toward political simplification. Decoupling rationalization from the expansion of coverage implies doing fewer things at once. The real issue, however, should be not the complexity of legislative or regulatory provisions, but whether the public can understand what is fundamentally at stake, what the proposed changes would mean for them, and ultimately how to negotiate the system to get the care they want and need.

Here “transparency” may be a better ideal than “simplicity.” Our health care system will always be complicated, but consumers will have more confidence in it if they have access to full information about its operation. The Internet today creates higher expectations of transparency than existed in the past—why, for instance, shouldn’t information be posted on Web sites? Why shouldn’t consumers be able to know about arrangements between health plans and their providers? Aren’t they properly concerned with such arrangements? In the past, health care providers and other organizations have often resisted public disclosure partly on the grounds of the cost of paperwork. But computerization and the Web reduce the costs of transparency. New technology makes reform more efficient when information is itself the means of reform.¹⁴

To be sure, it’s the organizations that need to become more transparent to the consumers, not the other way around. Just as consumers want to be assured that they have full access to information about their health care, so they want to be assured of the privacy and confidentiality of their own personal health information. System transparency and individual privacy are both preconditions of public trust. If we want to derive all of the benefits that new technology can provide, we are going to have to pay the cost that transparency and privacy protection entail. We also may need new forms of collaborative organization and fiduciary agents that provide trustworthy means of moving personal health data online.¹⁵

The new economy and new technology are unlikely to make the fundamental problems of health care reform any easier. They do not change—they certainly do not lessen—the moral interest in universal health coverage, nor are they likely to remove the political impediments that have prevented America from achieving that goal. However, if the new economy continues to bring about more rapid increases in productivity and growth than we experienced during the 1970s and 1980s, it will
change the context of our thinking about nearly everything in public life, including health policy. For years the ratio of health care expenditures to gross national product (GNP) seemed to grow uncontrollably, and we assumed that to slow it down we needed an increasingly harsh prescription for health care. By definition, though, any ratio also depends on the denominator—in this case, GNP. A sluggish economy sets in motion one kind of health politics; a dynamic one, another. A new economy with higher growth and innovation won’t necessarily bring us good health care for all, but we will have to think differently about the next steps in the effort to achieve it.

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NOTES

8. See, for example, M. Millenson, Demanding Medical Excellence: Doctors and Accountability in the Information Age (Chicago: University of Chicago Press, 1997).