It’s great to be here at the SAIS Bologna Center. The only American graduate institution of its kind in Europe, the Bologna Center provides students with an extraordinary experience. I wish to thank Ken Keller for his dynamic leadership and for the work that he and the resident faculty are doing in preparing our students to be global leaders, a proud legacy of the Center since its founding in 1955.

I want to talk to you today about health care policy and, in particular, some of the important characteristics of the newly enacted U.S. national health policy that I think deserve more attention than we have seen so far. I would love to hear more from all of you in our question period about the perceptions from abroad about U.S. health care reform. But I would offer this observation—or perhaps it is more of a proposition: not only America, but the world, will learn much from the approach that has been adopted.

Something that I think just about everyone here at the SAIS Bologna Center understands is the diversity of cultures and perspectives that there are in the world. Modern history is the history of societies and cultures and peoples intersecting and learning from one another and adapting new ideas and approaches. Of course some of that is not benign and happens in the context of violence and warfare and, too often, unimaginable brutality. But even, or perhaps especially, in the aftermath of such episodes—for instance, World War II—one can see the myriad ways in which new learning has come forth, and new and better models and institutions have been built through which people exchange, adapt, and learn from one another.

While such interchange and diversity is mostly for the good, it certainly comes with all kinds of difficulties when it comes to actually developing public policies and governing. For diversity, by definition, entails difference and nuance. Diversity brings with it the need for sensitivity and understanding of others as well as an appreciation of how interests both converge and diverge. These observations, of course, get to the nature and challenge of building and sustaining democratic states and institutions. At the core, success in this arena involves first, giving voice to diverse interests, and second, structuring the playing field so as to enable those voices to collaborate or compete in ways that are constructive and that enlarge upon the pursuit of prosperity, democracy, and basic human rights.
I say all of this in the context of an ongoing economic crisis that, while it has been stabilized to an extent, nearly took down the world’s economy not too many months ago. Not only does this crisis have much to teach us in terms of causation—or as we in medicine call it, the differential diagnosis—but it also has much to teach us about prevention and remedies and how a diversity of interests as complex as the world’s financial sector, must have rules and procedures not just for conducting business and dealing with routine adjustments, but also for managing crises and emergencies. Again there are parallels to medicine and health care systems.

Right now an interesting study in the actual interface of economics, public policy, and health care is being transacted in the United States. As everyone is aware, seven months ago, the United States Congress passed, and President Obama signed, a major health care overhaul. Known as the Affordable Care Act, the bill is a poster child for the kind of “sausage-making” that occurs in the attempt to address a diversity of interests and needs while, at the same time, trying to achieve an overall coherence. The goal of such coherence, from the point of view of those moving the bill forward, was to set and achieve benchmarks for health and cost control. I do think that we can find coherence in this particular example of sausage making, and I would suggest that it is not “socialism” by any definition of the term. It is, instead, a very American brand of sausage that I have labeled “the Blues.” Furthermore, I do believe that many of the principles embedded within the Affordable Care Act are suitable for export, which is what I want to talk about briefly here today.

One of the things that makes policy so difficult to craft in a democracy, where we pay attention to what “the people” want and care about, is that constituencies of all sorts have learned to become very good at what has been referred to as “manufacturing consent.” By this I don’t mean literally that spin doctors, lobbyists, or policy analysts manufacture the consent of the governed. What I mean is that we have a marketplace, but one that has some players that are much bigger than others. And we have a variety of industries and institutions whose primary purpose is to sell ideas or to induce particular behaviors, whether consumerist or otherwise. That, of course, is the purpose of the advertising industry, which saturates our lives with messaging in every medium and at every turn. And of course, there are many other major sources of such saturation: everything from political parties, to educational systems, to interest-groups and associations, to the media itself.

Suffice it to say that however people get their information and perspective, it is not necessarily the case that all of this information ends up being easily organized or understood. And certainly it is not always internally consistent or consistent with external realities either. In our health care debates, to give just one instance, some saw merit in the efforts of the legislation to create a non-partisan board to recommend cost savings. Others branded this same proposal as an effort to create “death panels.” Comfort with existing systems can obscure a realization of their underlying structure and organization. Witness the widely reported response during the recent health care debates, “Keep government out of my Medicare.”

When one thinks about the forces arrayed in modern society capable of influencing public perception and public policy coupled with the challenge for the individual in making sense of all of this, one comes
to realize just how difficult it is to craft public policy and to define the overall values, as well as the particular policies, that honor and enable the consent of the governed in a democratic system.

Here’s another example: since the 1990s, large majorities of Americans have consistently stated that the health care system is broken and needs major reform. Yet, at the same time, large majorities of Americans are pleased personally with the health care they receive and with their health care plan.¹

It is not difficult to see how hard it can be to tease out what the policy response should be in the face of seemingly contradictory perceptions.

But when you look at the facts, it has been well documented for decades that the United States does worse on many measures than the rest of the world. Here is one: mortality amenable to health care, a measure of health system performance. The United States ranks worst in terms of preventable deaths per 100,000 people. Although several nations were actually worse in 1997-98, they had all surpassed the U.S. on this measure by 2002-03.² Another is infant mortality: again, the United States has significantly worse outcomes in terms of infant deaths per 1,000 live births.³ On many other measures, the United States fares badly by comparison.⁴ And international comparisons of health spending are quite stark as well with the United States having significantly higher health expenditures per capita and as a percent of GDP than any other developed country.⁵

While there could be debate about performance reported on the quality measures I just discussed, and there certainly has been and will continue to be debate on how to improve performance on these quality measures, there is little debate over the observation that the projected rise in health care costs is economically unsustainable. According to the Congressional Budget Office (CBO), in the absence of changes in federal law, total spending on health care would rise from the 16 percent of gross domestic product (GDP) reached in 2007 to 25 percent in 2025, and 37 percent in 2050. Federal spending on

⁴ Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and OECD Health Data, 2009 (Nov. 2009).
⁵ OECD Health Data, 2009 (Nov. 2009).
Medicare (net of beneficiaries’ premiums) and Medicaid would rise from four percent of GDP in 2007 to seven percent in 2025, and 12 percent in 2050.⁶

At around the time the health care reform bill was passed, the CBO estimated that reform would have the effect of reducing the federal deficit, but there is still much disagreement among economists about how much overall health expenditures will be affected. Bending the cost curve would mean, at the very least, slowing the rate of increase in health expenditures. Much will depend on how various aspects of the bill are rolled out, including some I will be discussing. And much will also depend on how the bill might be changed by Congress over the years between now and 2019. Suffice it to say that bending this cost curve will remain a major challenge.

So, what is the plan to address these and other issues in American health care? The Affordable Care Act. This is an enormous bill and not easily summarized, so I am picking out some of what I believe are the relevant highlights.

One of the first things to know about the Affordable Care Act is that it is based in the largest expansion of private sector health insurance in U.S. history. There will be federal assistance for those without employer coverage and incentives to expand job-based coverage by providing tax credits for small businesses that provide insurance. This has already begun.

This expansion of private coverage is accompanied by a remarkable restructuring of the private insurance market, so that when fully phased-in, insurers will play by new rules. These will include:

- Policies that restrict or eliminate much of the capacity to build their profitability around delaying, denying, or limiting coverage.
- Policies requiring health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85 percent for plans in the large group market and 80 percent for plans in the individual and small group markets (requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011).
- Requiring states to report on trends in premium increases and recommend whether certain plans should be excluded from insurance exchanges based on unjustified premium increases. The bill provides for grants to states to support efforts to review and approve premium increases (effective beginning plan year 2010).

All of this is meant to change the marketplace so that insurers will compete mostly on quality, service, outcomes, and price, which, theoretically, could incentivize more efficient and cost-effective care.

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Another major aspect of the Affordable Care Act is the creation of insurance exchanges that are designed to provide a consumer-friendly marketplace for those individuals and small businesses eligible for this expanded private coverage. These exchanges will, in theory, more efficiently pool risk and lower administrative costs as well.

A third important element is a significant expansion of Medicaid eligibility to include about 16 million people who are currently uninsured. All Americans who earn less than 133 percent of the federal poverty level—in 2009 it was $10,830 for an individual—will become eligible for Medicaid. For the first time, Medicaid will offer coverage solely on the basis of income and regardless of family circumstance, including the single adults without children who are now excluded. Normally this program is a 50/50 cost sharing split between the federal government and state governments. This new expansion will be rolled-out with the federal government picking up 100 percent of the tab through 2019 and 90 percent after that.

The design of both the exchanges and the Medicaid expansion is to enable the states to take initiative and exercise administrative control over these programs so they can be tailored to local, state, and regional variables.

Overall, the goal of the Affordable Care Act is to cover all citizens. The reality is that, if all goes according to plan (how likely is that?), the uninsured will probably fall from close to 50 million today to an estimated 23 million by 2019. The remaining uninsured will be mostly “illegal aliens,” who are excluded from the new coverage, and those who fail or refuse to enroll in the new and expanded insurance programs.

There is one more aspect of the Affordable Care Act that must be mentioned here: there is an insurance mandate. All citizens are going to be required to be enrolled in a certified health insurance plan. While this is certainly one of the most controversial aspects of the bill, the rationale is obvious: under the new insurance marketplace rules, private insurance simply would not be viable if everyone could wait until they got sick to enroll in coverage. The only way to get to universal coverage in this private sector based system is to require all to become subscribers. This requirement is one reason why the Affordable Care Act calls for limits on the percentage of household income that can be expended on health care premiums and why the federal government will be providing significant subsidies to help people of all income ranges afford coverage.

There is so much more, but I will stop here for the purposes of this presentation and would be happy to talk about other aspects later.

To put the American reform effort into some context, let me just briefly review what we all know about most other national health care systems. Generally, there are three models in the most industrialized countries. One is the Bismarck social insurance model, which Italy, once favored. In this model:
• Patients pay insurance premiums to a sick fund (local/regional social insurers).
• These local/regional social insurers contract with first-line general practitioners and second-line specialists and hospitals.
• The role of the state is restricted to setting umbrella terms for contracts between patients, providers, and insurers.
• So, the model is decentralized and locally controlled.

The second national health model is the Beveridge National Health Service (NHS), which Italy, among others, has moved to. The Beveridge NHS model was established in the United Kingdom by Lord Beveridge in the aftermath of World War II and is funded through general taxation. In this model:

• The state owns and runs hospitals.
• A ministry of health, or some other such body, controls the health care budget.
• General practitioners are gatekeepers; patients need referrals.
• Obviously, this is a very centralized model.

In the United States and a few other nations, we find market-based models, which I will return to in a minute.

The Bismarck model is employed, with many variations, by countries such as Germany, France, Switzerland, and Japan. The Beveridge model is employed by countries such as the UK, Sweden, and Australia. It is interesting to note that the nations of Greece, Italy, Portugal, Spain, and South Korea transitioned from away from the decentralized Bismarck model to the more centralized Beveridge model during the 1980s. By the mid-1980s, virtually all nations were struggling with rising costs, persistent inefficiencies and inequities and this transition was a means of adding global cost controls and other efficiencies, and also of addressing regional and local disparities in quality and standards of care.

At the same time, centralized systems, feeling the price pinch for other reasons, began to delegate more control regionally and locally to enable more capacity to be responsive to local needs and to reform embedded and inefficient bureaucratic rules and processes. For example, the UK and others experimented with managed care.

Having pointed out earlier the American public’s seeming contradictory perceptions about their health care system and their care and how that renders policymaking difficult, I must point out that America is not alone in this. As just one example, some research suggests that popular satisfaction in more locally controlled Bismarck systems is higher than in centralized Beveridge systems, despite evidence that the more centralized systems do seem to achieve better cost control and better outcomes in disease requiring systematic, organized population-based screening, like breast cancer and TB.  

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This may not be surprising, really. One study suggests that systems that utilize general practitioners as gatekeepers tend to be less popular. I guess Americans are not alone in favoring more freedom of choice and fewer waiting lines!

The Bismarck and Beveridge models pretty well account for the majority of national health care systems but not all. (I’m not going to talk about socialist systems.) There are of course the market-based systems in the United States, South Africa, Uruguay, The Bahamas, Chile, and Argentina. These systems are based in a private insurance market, a private provider market, and access to care generally depends on the ability to pay. Many such systems do make provision for the poorest and most vulnerable, as America does primarily through the Medicaid and Medicare programs.

In the United States, the viability of a private insurance model was first established in 1934 by Blue Cross and Blue Shield. This model was vastly expanded and supplemented by employment-based insurance after World War II. Other models followed, including HMOs, and we have seen variations of these models ever since.

So, while virtually everyone else has Bismarck or Beveridge, America has “The Blues.” Doesn’t that seem fitting! And now, America, for the first time, has committed itself to universal coverage and that commitment is rooted in this market-based Blues model.

However, as we know, this is not as clear cut as it might first seem. While the U.S. health care system is rooted in the private market system, it is also supplemented extensively by both Beveridge and Bismarck programs. It’s not hard to see the mark of Beveridge in the Veterans Administration Health System and to some extent in Medicare. And it is not hard to see the mark of Bismarck in the state-centered Medicaid system and in our federally-sponsored community health center programs. In fact, it is very difficult to imagine the Blues model being able to function without these major supplemental non-market-based programs that have developed specialized expertise in providing health care for the poorest and most vulnerable.

It is also very hard to imagine how the Bismarck and Beveridge systems could continue to function well without learning from and incorporating elements from the other. Of course, it’s hard to generalize about the course of reform in so many nations, let alone one. The multitude of changes and corrections that one can chronicle in each nation, and even in any part of one, is staggering. But it is safe to say that many if not most nations that began from a decentralized approach are now experimenting with, or have in fact adopted, a more centralized approach. By the same token, many or most of those nations that started from a centralized approach have found themselves adopting and experimenting with more decentralized approaches tailored to particular regions, populations, or constituencies.

Interestingly, both Great Britain, the birthplace of the national health system, as well as The Netherlands, have long experimented with “managed competition.” Britain’s new government has proposed to decentralize much of the control over utilization and cost to general practitioners. Both of
these strong national health system-based countries are trying to understand better what greater reliance on market forces and competition in the health care system might mean for their still ambitious universal and equitable health care goals. In other nations, like Spain and France, proposals for privatization have not been as well received, to put it mildly. But it is notable that such reform ideas are now on the table.

And when one steps back a bit and thinks about the challenges any society faces in developing a health system to meet the health needs of its inhabitants, all of this borrowing and experimenting back and forth would seem to be both natural and necessary.

One challenge I haven’t talked much about is one I referred to early-on: the challenge of bending the cost curve. It is primarily, though not solely, the pressures of ever-expanding health budgets that have driven major health system reforms.

This is an enormously complex policy problem, with as many variables and uncertainties as one might find in an advanced fluid dynamics problem. I think it is safe to say that just about every nation has done pretty well at picking the low-lying fruit. In the U.S., we have succeeded in significantly reducing hospital stays and effecting a transformation where so much of our health care is now delivered in presumably lower-cost outpatient settings. And certainly there is much more to be done, like standardizing billing and collections and insurance policies, which could take tens of billions of dollars, say five percent of national health expenditures, out of health sector costs.

Nevertheless, most of the remaining and fast-growing costs in health care are in two places: hospital charges and physician reimbursement. As one can imagine, conversations surrounding and involving these constituencies become very complex, very quickly.

The Affordable Care Act tries to get at these through the proposed creation of Accountable Care Organizations, known as ACOs. The idea, briefly, is to reorganize both health care delivery and payments so that providers are paid for producing good outcomes rather than for simply providing health care services. The market-based incentives here would be that providers would negotiate a bundled payment for episodes of care or based on capitated lives, and then they would be incentivized to find the most cost-effective processes to get to the best results. ACOs can be categorized by the mode of payment, savings incentives, and the degree of risk they assume. There are several types of organizations (such as hospitals, physician groups, and systems of health care delivery) that could be brought together to form ACOs.

There are a number of problems with the ACO model, including that the federal government only really has control over Medicare and Medicaid payments, and even there, not so much, given some of the

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8 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
Affordable Care Act’s provisions. Additionally, the incentives to create more efficient and effective processes, teams, and organizations could also have the effect of incentivizing under-utilization, potentially putting patients at risk.

I also want to bring forward another very important consideration in the quest to control health care costs in the United States. Interestingly, the United States spends far less than other developed nations on social service expenditures. Yet, as we have already noted, the U.S. spends far more on health care. But when you put them together, you get essentially equivalent total expenditures. So, overall, quite contrary to popular belief, the U.S. spends about as much on social programs as other advanced industrial nations. But we in the U.S. still have far worse outcomes in a number of different areas.

New studies, many of these emanating from work sponsored by the World Health Organization, are demonstrating that social determinants of health account for far more ill-health than the relative level of health care spending. In fact, it seems that health care spending directed at disease intervention addresses only about one quarter of the determinants of health. Where America lags compared to other nations is in supporting services that would affect other critically important factors, like poverty, social status, and social capital, which are essentially a measure of life chances.

With this growing knowledge, these social determinants of health need to become increasing targets of social policy. I suspect that we may find many opportunities for reducing the costs of health care and improving health by focusing on these factors. These include things like prenatal care, early childhood nutrition, programs to alleviate poverty and to provide transportation and daycare for working parents, and better schooling for children. These and many more targets have long been standard in many other nations’ social programming and supports, with apparently very much more positive outcomes in terms of overall health and reduced mortality.

Another thing to know about the United States that can be very helpful in guiding policy for better outcomes and lower costs is that our relatively poor record in health care quality, outcomes, and cost is, in significant part, a regional issue. There are significant differences among the states in terms of infant mortality, for example. What these data suggest is that there is much to be done and gained by targeting these regions for both better access to health services and for a broader array of social services and interventions that can address the broader social determinants of health. The Affordable Care Act contemplates enabling states and localities to define locally appropriate health benefits and

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10 OECD Health Data 2009 (Accessed June 2009); OECD Social Expenditure Dataset (Accessed Dec. 2009); Health and Social Service Spending; Associations with Health Outcomes by Elizabeth Bradley, Benjamin Elkins, Brian Elbel.
11 Sowad, B. J. A call to be whole: the fundamentals of health care reform, CT. 53.
access, and there are many programs within the law that can fund state- and institutional/provider-based efforts to address local and regional population health issues.

I would like to end by suggesting that, in a tongue-in-cheek sort of way, American health care has “The Blues” and that having “The Blues” suggests some very exciting possibilities. As a national framework for health access and services, it does allow America to build on what it knows best but within a national framework. It also bolsters the complementary Medicare, Medicaid and related community services.

And so in closing, if you will allow me, I will draw on the double entendre in this idea and point out what an enormous impact “The Blues” have had not just in America, but throughout the world as they were progressively exported and adopted. As Brownie McGee taught us, “The Blues is Life.” Most Americans and many on this and other continents understand this well. And as his compatriot, James Weldon Johnson said, “It’s from the Blues that all that may be called American music derives its most distinctive characteristics.” Dare we think that one day, health care systems worldwide might be informed by a new incarnation of the American Blues? I wouldn’t rule it out.