Taking the scare out of Obamacare

Forget 'Soviet-style' reform, it could mean more competition

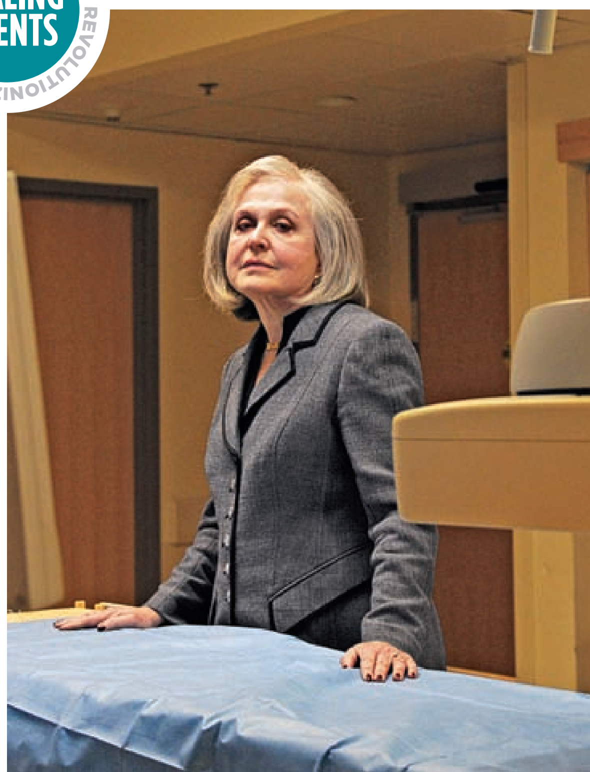
BY ANDREW COYNE • Most opposition to the Obama health care reforms falls into one of two groups: those on the left who lament that it did not establish a public health care monopoly ("single payer"), and those on the right who fear that that is where things are inevitably headed ("government takeover"). Regina Herzlinger takes a different view.

The Harvard Business School professor and renowned health care analyst has mixed feelings about the Obama plan itself: pleased at the extension of coverage to 34 million currently uninsured Americans, but worried about the costs to the public treasury—another $2 trillion, she expects, on top of the existing $38 trillion unfunded liability for Medicare, the public insurance plan for the elderly. Like many experts in the field, she thinks the administration has not begun to properly account for these costs. "The notion that we're going to find half a trillion dollars from cuts in benefits," she says, "I think is dubious."

But far from leading to a government takeover of health care, as many fear, Herzlinger believes the knock-on effect of Obamacare will be to hasten the emergence of a market for consumers to purchase health care for themselves and their families, rather than relying, as now, on employer-provided plans—the very "consumer-driven" model of health care she has advocated in three books and countless articles and speeches over the last decade. From a system designed around the interests of insurers, hospitals, governments and employers—the leading culprits identified in her latest book, *Who Killed Health Care?*—Herzlinger sees the beginnings of one that caters to the demands of individual consumers and patients.

At first glance, that seems counterintuitive. The Obama plan, with an eye to the politically possible, aimed at bolting on some of the missing pieces in the current system, rather than radical change. To the existing employer-based model, it added a requirement that employers must offer their workers health insurance, enforced by fines for those that refuse. Individuals face a similar requirement, or "mandate," to purchase health insurance on exchanges to be set up in each state, with subsidies for those to whom this would present an obstacle. Insurers will be required to accept all comers, rather than screening out those with "pre-existing conditions."

So far, so bureaucratic: the same system, only more obligatory. But Herzlinger says employers are about to rebel. Sensing an opportunity in the individual mandates and subsidies of the Obama plan to relieve themselves of the soaring costs of providing their own health insurance plans, many will choose, she says, to scrap their plans, and compensate employees with cash instead: even with the fines, it would still be cheaper than maintaining them.


HARVARD'S Regina Herzlinger sees more choice for patients

With millions of individual consumers surging onto the market, she argues, the "Soviet-style" exchanges, with the limited menu of options currently envisaged (all in the name of cost control), will come under pressure to become real health care supermarkets, offering plans for every taste and pocketbook.

How to encourage consumers to be mindful of costs? Include a high deductible, as the Swiss do, obliging consumers to purchase the first few hundred dollars of care themselves. How to discourage insurers from cherry-picking the healthiest cases, Obamacare's proscriptions notwithstanding? Pay them more for taking on clients in riskier groups. And let insurers form profit-sharing co-operatives, removing the incentive to screen out the sick (since any profits gained from this practice would only be redistributed back to the insurers who were willing to take on those patients).

It's an intriguing vision, from an analyst who has already done much to influence the debate on health policy in the United States, and Canada. It was Herzlinger, for example, who introduced the concept of the "focused factory" to health care—small clinics that specialize in a narrow range of procedures, rather than the comprehensive services provided in general hospitals.

It fits with a general "small is beautiful" approach to health care: the system has suffered, she says, from too many attempts to impose solutions from above, however rational they may have seemed at the time. Included in these would be the last major attempt at health care reform, the Clinton plan, built around the then-dominant model of the health maintenance organization. Once touted as the future of health care, HMOs fell apart in the 1990s as the original, tightly integrated web of providers, insurers and hospitals devolved into looser purchasing networks, without the cultural ties that once bound them to each other. Rather than finding newer and better ways of delivering care, they achieved savings simply by skimping on payments.

Sound familiar? For all their differences, the American and Canadian systems share certain pathologies, notably the absence of price signals or other incentives to control costs. In place of competition and innovation, each attempts to achieve savings, when the funds run out, via various forms of rationing. Could Herzlinger's thinking, then, be adapted to Canada's public health care system? That's one of the questions I'll be exploring with her, at the next "In Conversation with *Maclean's*" event, May 18 in Toronto. M

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