

Team proposes "single system solution" for US healthcare system

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The coronavirus pandemic has highlighted the numerous weaknesses in the U.S. healthcare system. Millions have lost their health insurance and millions more can barely afford it. Racial, ethnic, economic, and geographic disparities in health are widening as death rates from COVID-19 rise. And the financial solvency of hospitals and physician practices is at risk. At some point soon, health care reform will be high on the political agenda.

In the lead article for the current issue of *NEJM Catalyst Innovations in Care Delivery*, Elliott Fisher, MD, MPH, professor of medicine and [health policy](#) at Dartmouth, and one of the policy leaders who developed the concept of Accountable Care Organizations, lays out a path to reform that would provide universal coverage, real-time data and performance measures, and more robust payment models that would enable the market to improve care for all through informed choice of population [health](#) organizations (PHOs), providers, and treatments.

"There is a real risk that policy makers will get

stuck in a fruitless debate between 'single payer' and 'multi-payer' approaches to achieving universal coverage," said Dr. Fisher. "If we get another crack at major reform after the upcoming elections, we should address the underlying reasons that healthcare in the United States is so expensive and unequal."

Responding to a pre-publication copy of the paper, Representative Peter Welch (D. VT), said: "Dr. Fisher helped develop the ACO model that has garnered strong bipartisan support. He has now clarified why costs nevertheless continue to rise and how we could do better. Dr. Fisher's recommendations about how to empower the market to improve care and lower costs for all deserve serious attention. I look forward to working with my colleagues across the aisle—as we did with ACOs—to explore these ideas."

The concept at the heart of the proposal—Population Health Organizations—is intended to address the limitations of the current ACO model, under which primary care focused provider organizations are responsible for the quality and total cost of care for their assigned patients and receive a share of any savings they achieve if they continue to meet quality standards. More than 30 million Americans now receive care under this payment model. "We should celebrate the broad bipartisan support and high levels of adoption seen for ACOs and other value-based payment models," Dr. Fisher said. "And we must admit that while these models appear to achieve some savings, their overall impact has been less than what we hoped for."

In his Catalyst paper, Dr. Fisher explains why the U.S. continues to see the inexorable increases in costs that have made healthcare unaffordable for so many. "Fragmented delivery, payment, and insurance systems have long been recognized to pose serious challenges to care coordination," he writes. "Fragmentation also weakens incentives,

discourages innovation, and makes it easy for providers and insurers to avoid efforts to control costs." ACOs, for example, can be rewarded for lowering costs for the patients in their ACO contract while at the same time increasing [costs](#) to others. "Our current system can be seen as a balloon: push on one part and the expansion simply continues somewhere else."

The solution is to shift from thinking of ACOs as a contract to seeing them as organizations paid under capitation to manage the health of all of their enrolled primary care patients—as Population Health Organizations. Fisher recommends that all Americans get to choose their PHO on statewide insurance exchanges where uniform benefits, limited cost-sharing, and transparency on quality would enable market forces to drive meaningful improvement in both cost and quality.

Other key elements of the "Single System Solution" include:

- A single, unified health information system, ensuring that clinicians have all of their patients' health records when needed and where comprehensive quality and outcome measures empower consumer choice of treatments, providers, and PHOs;
- Universal coverage under which everyone would have access to the same basic benefit packages and choice of PHOs on statewide exchanges, which is the single best way to reduce disparities and eliminate the sense of exclusion experienced by those now relegated to the "safety net."
- Administrative simplification and a uniform fee schedule, with common benefits (instead of an infinite number of plan designs), a single billing system, and a national fee schedule that would not only reduce the influence of monopoly pricing but reduce the violence done to physicians' professional values in a system that encourages providers to discriminate on the basis of patients' ability to pay.

Provided by The Geisel School of Medicine at Dartmouth

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