Universal Insurance for American Health Care
A Proposal of the American College of Physicians*

America urgently needs comprehensive health care reform. The American College of Physicians (ACP) believes that universal access to care can be achieved only through system-wide reform in the organization and financing of health care (1). This paper outlines our proposal for a national policy to achieve that reform.

Overview

As a professional society of physicians whose goal is excellence in medicine, we see a system failing all who are a part of it—patients, physicians and other health professionals, purchasers, and insurers. Most of the problems have been well documented: over 35 million Americans without health coverage, excessive utilization of high technology coexisting with substandard care, astonishing increases in spending with commensurate gains in health status, acute care promoted at the expense of preventive services and technology-based care at the expense of primary care. As practitioners, we feel the fear of uninsured and underinsured patients at the prospect of severe illness, and appreciate the dilemma of those locked into jobs just to keep health coverage. We confront every day the crushing bureaucracy of a system that diverts time, energy, and resources from patient care, frustrating the ability of physicians and patients to deal with illness.

Three aspects of the health care system appear particularly troubling. First, it promotes inequity and conflict between its private and public components. Costs are shifted from one component to the other, public programs lacking a powerful constituency are underfunded, and the total system suffers from unwieldy administrative complexity and cost. Second, benefit packages consist of circumscribed lists of covered services that reflect more the needs of payers than those of the patients. Third, cost-control efforts have failed to make the system affordable and have imposed an intrusive regulatory burden on both patients and physicians.

The College would correct these problems through a universal health insurance system covering everyone living in this country. Our design for a reformed system addresses the major problems through four elements:

- Assuring Access to Care: We propose a universal insurance system that relies on employer and publicly sponsored insurance plans. All public programs for health care would be consolidated, and everyone would be guaranteed coverage, funded through a combination of private premiums and public revenues.
- Assuring High-Quality and Comprehensive Health Care: We propose that all medically effective services be covered when they are appropriate for a particular patient.
- Promoting Innovation and Excellence: We propose measures to enhance the crucial institutional underpinnings that sustain excellence in medical care—research, education, and medical information management.
- Controlling Costs: We propose a national health care budget with a mixture of centralized and decentralized mechanisms to influence the price, volume, supply, and demand for health care services.

The ACP plan envisions substantial change, including insurance reform, limitations on spending, fee negotiations, and new structures such as a national health care commission representing all sectors of society. At the same time, the College's plan would incorporate elements of our current system that are valued by patients and providers—for example, a pluralistic approach that would accommodate fee-for-service and managed-care options, but a role for government that is circumscribed.

The College has developed this plan after extensive consultation, including input from a network of 4500 ACP members and from many organizations, review of other proposals, and examination of health care systems of other nations. Careful transition will be essential, but the nation must move forward quickly to adopt and implement a comprehensive plan.

Assuring Access to Care

The College proposes a plan for universal insurance, through a mixture of private and public financing, in which everyone living in the United States would be insured. Covered benefits would be the same for everyone: all medically effective and appropriate care. Public plans serving specific segments of the population would be eliminated.

We envision an integrated system in which employer-sponsored and publicly sponsored insurance plans would offer practice arrangements ranging from traditional fee-for-service to various organized delivery systems. Patients and providers would perceive no difference between health care in employer-sponsored and publicly sponsored plans; only the source of financing would be different.

Other proposals have suggested separate systems of care: private insurance through employers, public coverage for the unemployed, and continuing entitlement...
programs for others (Medicare, Veterans Affairs, and other programs). Separate public and private systems perpetuate inequitable access to care, both because people in some public plans have only “minimum” benefits, in contrast to full benefits in most private plans, and because public programs are likely to be underfunded. Separate systems also perpetuate complex, overlapping, and costly administrative bureaucracies.

Some proposals rely on single-payer or centralized government approaches—basically a Medicare program for all. Government may be efficient at some functions, like collecting taxes and writing checks, but it is not well suited to administer and oversee the complicated set of interactions in the health care system. Nor would centralized control promote the variety of approaches to health care delivery that a private, insurance-based system fosters.

Employer-Sponsored Insurance

In the ACP plan, employers would have an option: They may sponsor insurance for employees up to 60 years of age and their dependents (including part-time employees) or pay a tax so that those employees can enroll in a publicly sponsored insurance plan. To encourage employers to sponsor plans, we propose three steps to make coverage more affordable and premiums more predictable:

- phase out employer responsibility for retirees and shift them into publicly sponsored plans;
- switch employees into publicly sponsored plans at 60 years of age; and
- provide payment for all catastrophic costs (over $50 000 per year per person) through publicly financed coverage.

These measures would remove the most expensive patients from employer-sponsored plans. The intent is to make premiums equal to or less than the payroll tax that would otherwise be required, encouraging employers to continue or initiate coverage. This addresses a criticism of those “play or pay” plans in which the premium cost to “play” is so much higher than the tax to “pay” that employers would terminate coverage and transfer employees to the public program—eventually leading to a single public system.

Employers who sponsor insurance would choose among private plans that meet national guidelines. The minimum employer contribution to the premium would be 50%, with the employee paying the rest, although the employer may choose to fund a larger proportion of the premium.

Publicly Sponsored Insurance

Everyone not covered by employer-sponsored insurance would enroll in a publicly sponsored plan. This group would include: employees whose employers choose not to offer plans, employees over 60 years of age, retirees, and the unemployed and those outside the labor market. The current array of federal and state entitlement programs created for specific groups would be replaced by the publicly sponsored insurance plans, which would provide benefits identical to those in employer-sponsored plans.

Funding for publicly sponsored plans would come from:

- payroll taxes from employers and employees in companies not sponsoring insurance;
- income-related premiums, collected through the tax system, for retirees and people not working but with incomes greater than the poverty level and for employees over 60 years of age in firms sponsoring insurance;
- increased alcohol and cigarette taxes; and
- general tax revenues.

The general revenues will be necessary to support premiums for low-income and unemployed people who pay no or reduced premiums, to pay for catastrophic coverage, and to cover costs for the elderly beyond premium revenues. We believe these expenditures are properly the responsibility of the public.

Our catastrophic costs program would be not only a public payment mechanism for costs in excess of $50 000 per year but would also be a stimulus to development of high-cost case management techniques, reliance on centers of excellence, and cost-efficient care. Our goal is to encourage smart decision making to govern allocation of resources.

The ACP approach to publicly sponsored insurance would strengthen the constituency of public programs. By including employees and dependents from companies not sponsoring insurance, retirees, and anyone facing catastrophic costs, the publicly sponsored plans would have strong backing under this proposal. Every person would have a stake in the system.

Insurance Plans and Insurance Reform

We believe an insurance-based system offers the best means of fostering a wide range of practice arrangements to suit the needs and preferences of patients and providers. This does not mean we approve of how private insurers have handled coverage in the past. We propose substantial reforms to alter their practices. We also believe system administration is best handled at the decentralized level, under national criteria.

Insurance plans would not compete on the basis of benefits offered, because all plans would cover all effective and appropriate care. They would not compete by underpricing reimbursement to providers, because there would be uniform rates for all payers. And they would not compete by excluding sick people.

Insurance plans would compete on the basis of premium price and value offered to employer and public purchasers. By better administration and other efficiencies, a plan could offer a lower premium. Another plan might market itself as providing better value at the same or even a higher price—for example, by organizing a group of providers it believes provides higher quality care. Traditional indemnity plans reimbursing fee-for-service providers could continue under this approach and might compete by offering greater value—for example, unrestricted choice of providers. Insurers might also compete by offering benefits beyond those covered,
although under the benefits process outlined below, we do not see much of a market for that option.

Our plan should reinforce the movement of physicians and hospitals, as well as purchasers and payers, to organize more effective and efficient delivery systems to enhance their competitiveness. There would be strong incentives to develop criteria for quality of care, measure outcomes, and help practitioners provide effective and efficient care.

Competition among insurers would be channeled in this positive direction through reforms to eliminate the current risk-avoidance practice of insurers. Insurers would be required to accept all applicants. There would be no exclusions of coverage due to health problems (“preexisting” conditions). Experience rating (premiums calculated on the health status of the group), which has made rates unaffordable for many small groups, would be eliminated in favor of adjusted community rating (premiums that reflect the health status of the entire community) for all employers.

Finally, with insurance for all medically effective and appropriate services, individual state health benefit mandates would be eliminated.

Underserved People

Even with extension of health insurance to all, there would likely remain underserved people, including the poor, minorities, and rural populations. Providing insurance coverage is insufficient if the barrier to care is lack of nearby physicians and health care facilities. People in inner cities and remote rural areas as well as migrant workers will need more than an insurance plan. We therefore support an expansion of the public health system, including community health centers, local health departments, and the National Health Service Corps, and other ways to deal with geographic maldistribution of health care workers and facilities. Education reforms and related incentives are essential for producing providers to meet the needs of the underserved.

Fiscal, professional, and lifestyle incentives will be necessary to attract and retain health professionals in underserved areas. Capital will be necessary to develop or upgrade facilities and equipment. More effective integration of health services will be required, including efficient transportation and communication. Telephone and computer-based links and mobile clinics may help to deliver care to patients in sparsely populated areas. Strategies must consider cultural differences that influence how care can be delivered effectively.

Assuring High-Quality and Comprehensive Health Care

The College proposes a patient-oriented benefits determination process. Under our plan, a national health care commission would be responsible for determining covered benefits—with the requirement that all medically effective services be covered—and setting and allocating budgets. The commission would have representation from patients, physicians and other health professionals, employers, insurers, government, and other key sectors of society.

All effective and appropriate health services would be covered under all publicly sponsored and employer-sponsored plans. The scope of benefits covered would be based on medical effectiveness research and expert consensus. We would further ensure high-quality care by promoting practice guidelines, creating a scientifically reasoned system of quality assurance, and redefining malpractice protection.

Benefits Determination

For determining benefits, we propose a cascading process structured around three questions of increasing specificity to the patient.

1. Is a service medically effective?
2. Is the service medically appropriate for a particular group of patients or set of clinical circumstances?
3. Is the service appropriate and of value to a particular patient?

Effectiveness

The question of whether a service is medically effective is answered by research or expert consensus. Effectiveness extends along a continuum from clearly ineffective, to unknown/unproven but promising, to somewhat/sometimes effective, to clearly effective care. Decisions at the extreme are clear, but decisions become complex for interventions in the middle range. Greatly expanded efforts in medical effectiveness research will be essential to ensure that clinical decisions would be based increasingly on scientific data and less on individual opinion. Meanwhile, we recognize that there are procedures and therapies that clinical consensus would deem effective but that have not been scientifically evaluated. Such interventions should not be excluded from coverage while their effectiveness is being measured, but measurement should be expedited.

Services that would be assessed for effectiveness would represent all aspects of health care: preventive care; primary care; medical, surgical, and psychiatric care both in-hospital and in outpatient facilities; ambulatory mental health and substance abuse care; oral health; rehabilitative services; and prescription drugs. The medical care needs of patients in home-care programs and nursing homes will also be included.

The national health care commission would be responsible for determining covered benefits and for establishing the global budget. Should rationing of care become necessary, this mechanism would allow decisions to be explicit and apply to everyone, in contrast to the rationing now done tacitly through the allocation of resources, and largely affecting the poor. These decisions will confront the commission clearly with the trade-offs between expanding medical technologies and limited resources.

The commission’s proposals on what services would be covered would not be subject to selective change by Congress. Congress could reject the entire package, but not add, delete, or modify individual items.

Appropriateness According to Guidelines

For services deemed effective, the next step would be to determine the appropriateness of the service under
practice guidelines developed by the clinical community. Guidelines may indicate that a particular procedure is effective for some patients but ineffective for others. As an example, annual screening mammography is effective and indicated routinely for women in their 50s but not in their 30s.

Practice guidelines should be professionally developed and viewed primarily as a means for assisting physicians and patients in making appropriate clinical decisions. They will also help correct over- and under-utilization. It is important they not be viewed as a cost-control mechanism.

Guideline development is a science in its infancy. The College has committed our resources to developing guidelines, and we call for increased public and private funding. For the present, guidelines should be applied judiciously, with reliance more on those for which there is strong scientific evidence and less on those for which there is controversy or insufficient evidence.

When practice guidelines are available, they would be tied to the profiling of practice patterns to determine if a physician is generally following the criteria for clinically appropriate use of services. "Generally following" is the key phrase: Oversight would look at patterns, not at individual case decisions. If a practice pattern consistently deviated from guidelines, there would be reason to challenge payment for services. If guidelines are not available, practice profiles would allow comparison with community norms.

**Appropriateness for an Individual Patient**

Clinical guidelines may not always apply to a specific patient, because guidelines are usually more general and apply to patient groupings. Individual patients may have unique characteristics not covered by the guidelines. A physician may decide, in consultation with the patient, that it is reasonable not to follow the guidelines. This decision will reflect individual clinical circumstances and the personal values of the patient. After the physician provides a service that is medically effective and appropriate for the patient, reimbursement would be made. There would be no questioning of decision making or denial of reimbursement. Payment could be challenged only retrospectively, and only if the physician's practice pattern, indicated through profiling, consistently departed from guidelines.

**Other Considerations**

To promote innovation, the benefits determination process must accommodate experimental procedures, tests, and therapies. We propose that experimental diagnostic and therapeutic services be evaluated for clinical effectiveness. Insurance plans would cover experimental services if both the physician and patient agree to participate in a formal, scientific evaluation sanctioned by the national health care commission.

We believe the process we have described would provide reimbursement for all appropriate services. Some patients, however, will want services beyond those covered. Others will want amenities such as a hospital suite. Under our proposal, people can pay for these services out-of-pocket or through supplemental insurance, but those expenditures would not be tax-deductible or included in the national health care budget.

**Quality Assurance and Utilization Management**

An essential element of systemic reform is restructuring the external oversight of quality of care. We believe physicians will accept the constraints necessary in a reformed system, particularly to control costs, if there is an end to the overwhelming regulatory intrusion that dominates practice today.

The goal of assuring quality has been displaced by the imperative of utilization management—a set of techniques designed primarily to drive down costs. Part of this trend has been the transfer of many of these review activities from the traditional setting of quality assessment (the clinical service, the hospital, the organized group practice) to the purview of insurance carriers, Professional Review Organizations, and a rapidly growing number of proprietary groups. These reviewers have relied mainly on time-consuming and intrusive case-by-case reviews. Review criteria are often unspecified and left to the judgment of the reviewer. The techniques are labor intensive, costly, and have not been shown to improve quality of care. Rather, they have intruded excessively into the daily clinical decisions of most physicians, and contributed to mounting frustration and dissatisfaction within the profession and among patients.

The College believes the primary locus of quality assurance must be returned to the medical profession and to health institutions. Clinicians should be responsible for providing high-quality, cost-effective care, and be held accountable for efficient use of resources. Concepts of continuous improvement should underlie this responsibility.

Under the proposed national health care budget, medical organizations would have the responsibility and incentive to monitor practice patterns because those would affect the resources available to the organization and the community. We envision a process tied to the second stage of the benefit determination process described earlier. Practice guidelines are used at this stage to determine the appropriateness of providing services in particular clinical circumstances. Profiling would indicate whether the overall pattern of a physician's decisions falls within the guidelines. Profiles would be relayed from the insurance plans to hospitals, organized delivery systems, and professional organizations so that they can identity outliers, determine reasons for the deviation, and help the practitioner make appropriate changes.
guidelines (2) and developing criteria to establish skill levels for procedures (3). Professional standards help identify good care. Continuing education keeps practitioners current in basic and clinical science and will help physicians meet the important new requirement of periodic specialty board recertification.

The profession must take greater responsibility for monitoring itself. Physicians must identify colleagues who are impaired or show evidence of deficiencies, correct problems, or, if necessary, limit the practice of those impaired physicians. Licensing boards must have the resources and the authority to enforce standards. Data on quality of care will be essential to these efforts. Federal and state governments, insurers, accrediting agencies, institutions, and the profession must agree on indicators for monitoring quality of care.

Significant tort reforms are necessary to defuse the malpractice crisis and begin the retreat from the defensive medicine so ingrained in physicians' patterns of thinking. Tort reforms may not have a dramatic impact, but they are a necessary beginning to restructuring the entire process of liability determination. For various constitutional and political reasons, most states have been unable to enact meaningful tort reform. The malpractice crisis is a national problem that demands a national solution. Congress can and must take steps immediately to pass legislation that preempts state tort law for malpractice, with the following reforms:

- a cap on awards for non-economic damages (so-called "pain and suffering" awards);
- the elimination of suits seeking full damages from all parties (joint and several liability);
- an offset of awards if there are collateral sources of recovery (insurance, workers' compensation, and so forth);
- a penalty for frivolous lawsuits;
- modifications to the statute of limitations; and
- limits on attorney contingency fees.

Also, it should be noted that universal coverage would eliminate costly awards for future medical care.

We reaffirm that the profession must set and enforce standards for physicians who serve as expert witnesses (4). The testimony of these physicians should be subject to ongoing peer review.

Although the jury trial is an ingrained part of dispute resolution in the United States, we question whether it is the best method to achieve the goals of the malpractice system: identifying substandard care and compensating injured patients. The College has been a founding member of the AMA/Specialty Society Medical Liability Project, which formulated an innovative administrative process for liability determination (5). There would be administrative review and appeal, with final determination by a state board. This model deserves serious testing, supported by adequate federal funding. We also support testing alternatives, such as pre-trial screening panels, to eliminate claims not likely to have merit in court, and mandatory arbitration, in which parties to a dispute are bound by the decision of an arbitrator.

### Promoting Innovation and Excellence

The American health care system must foster innovation and excellence in medical education, research, and data-based decision making. The College proposes adequate and dedicated financial support for each of these components of the "infrastructure" necessary for the delivery of high-quality medical care.

### Medical Education

Reform of medical education is necessary to encourage and enable more students to become generalist physicians, to provide specialty care efficiently, and to prepare physicians to manage patients under the constraints of a health care budget.

A critical element of education reform is that all payers, both public and private, be required to contribute a fixed percentage of health expenditures to graduate education. In addition, appropriate mechanisms to finance training in ambulatory care settings must be developed.

Financial incentives could be used to achieve a balance of generalists and specialists. Financing of graduate medical education might be limited to the number of years required for residency training in general internal medicine, family practice, and general pediatrics. Payments per resident could be weighted for the training of generalists. Reduced or interest-free loans could be granted, or loan repayments deferred, only for residents training to be generalists. Loans might be partially or entirely forgiven for generalists practicing in underserved areas. Increased federal and state grants could be provided to support residency programs for generalists. Other, nonfinancial methods may be required, including capping the number of slots for nongeneralist training, and limiting the accreditation of new programs.

The nation must broaden opportunities for medical education. The government should supplement funding of undergraduate medical education to allow minorities and lower income students greater access. Funding is an increasingly urgent problem; three fourths of graduating medical students have debt, with an average of over $50,000 (6).

Optimal health care requires that physicians educate themselves actively throughout their careers. A new and more effective health care system will require even higher standards of physician competence. Thus, a design for greatly improved continuing medical education, including more meaningful curricula, more effective learning methods, better integration with guidelines, and other quality improvement techniques, as well as expanded, stable funding, should be included in planning for a new health care system.

### Biomedical and Health Services Research

A major virtue of the U.S. health care system is its capacity to be innovative—in diagnosis and treatment and in delivering and evaluating care. Sustained investment in basic and applied research is essential to improve the health of the American people. To assure continued vigor in biomedical, clinical, and health services research, the College supports 1) regular increases...
in appropriations for the National Institutes of Health and 2) a percentage set-aside from total health care expenditures (for example, one quarter of one percent) to secure predictable funding for clinical and health services research.

Medical Information Management

The College is committed to informed, data-based decision making. This philosophy underlies health care reform. Informed decision making requires data systems to support excellence, not only in medical practice, but also in planning, policy development, and system administration.

To understand the dynamics of medical care and variations in use of hospitals and technologies, a reformed system must adopt common diagnostic and procedural codes, common indicators of quality of care, and a common data set. Unique identifiers for hospitals, physicians, and health plans would need to be standardized for statistical profiling to be meaningful and for evaluations of care. In addition, population-based data are essential to promote the effective distribution of health resources (manpower, technology, and facilities).

Controlling Costs

The United States cannot afford, and will not achieve, universal access to care without controlling costs, and costs cannot be controlled without system-wide reform. We must limit total health care spending, through a national health care budget and a matrix of national and local controls on the price, supply, and demand for health services. An effective strategy must incorporate both expenditure control and cost control. For expenditure control to be meaningful, participants must have tools to reduce costs; for example, if a community or hospital is to achieve an expenditure target, it will have to identify and eliminate redundant capacity such as competing MRI units. Our proposals would influence forces that determine the cost and utilization of services.

We recognize that these proposals raise politically and procedurally difficult issues. It will take time and care to work out the details. But no plan for reform can succeed without substantial efforts to control spending.

National Health Care Budget

At the heart of the College’s proposals to control costs is the recognition that the health care system must operate within financial limits. We must adopt a national health care budget—a ceiling on total health expenditures, sometimes referred to as a “global” budget. A national budget would take into account changing health needs of the population (including aging), new technology, and general inflation. What the budget should be is uncertain now, but we start with the assumption that the current level of spending, projected to be more than $800 billion in 1992, is enough to provide health care for everyone (7). This level reflects all the waste of the current system: administrative costs estimated by some in excess of 20% of spending, unnecessary utilization, duplicative facilities and equipment, overpriced care, and so on.

The national health care commission would recommend to Congress a health care budget for the nation, covering public and private spending and capital outlays. The commission, in consultation with state authorities, would develop a budget for each state based on its population and disease burden. The overall budget and state allocations would be updated periodically, based on changes in the variables that determine the need for health care and its true costs. In turn, states may choose to allocate funds to regional authorities within the state.

Providing good care within the constraint of fixed income is the underlying principle of the managed care industry (8). Other countries have shown that fee-for-service arrangements can operate within a budget, through negotiations over fees (9-12). Implementation of a national health care budget would be a forceful incentive for all providers, patients, and payers to begin to make decisions reflecting the need to operate within limits. The budget would give the authority to the planning process necessary to allocate resources.

Managing Price: Insurer-Provider Negotiations

States would be required to establish mechanisms for the employer-sponsored and publicly sponsored insurance plans to negotiate fees with physicians, hospitals, and other providers. Using systematic, research-based methods of valuing services, such as the resource-based relative value scale (RBRVS) for physicians and diagnosis-related groups (DRGs) for hospitals, insurers and providers would negotiate and agree on conversion factors to set yearly fee schedules. Uniform rates would apply under all plans within states or sub-state regions; all payers would pay the same price for the same service. Qualified managed care organizations, such as prepaid group practices, would negotiate an overall budget with all insurers based on enrollment, age distribution of enrollees, and expected morbidity; they could develop their own compensation packages for health care professionals. Organized delivery systems would negotiate budgets for institutions and practitioners within the system, to be allocated to providers under their financial arrangements. To permit these negotiations, antitrust restrictions must be revised.

The health care budget would encourage trends such as regionalized services integrated vertically and horizontally, primary care networks, multilocation group practices, and new organizational and financial relationships between hospitals and their medical staffs, all of which should improve quality and reduce costs. Because operating under a budget is normally part of these arrangements, the transition to a national budget should be eased.

Payments under the various fee schedules, when multiplied by expected utilization of services, could not exceed the state’s allocation under the national health care budget. A state health care agency would monitor utilization patterns by service category and study variations from predicted use. To stay within the state’s allocation, the state (or regional agencies within the
Managing Supply: Regulatory Approaches

Market forces have not led to appropriate distribution of health resources—manpower, technology, and facilities. Hospitals a short distance apart establish duplicative high-technology services. Running competing, partially utilized services is inefficient and leads to pressure to use the service regardless of clinical need. Freestanding outpatient facilities generate business to try to maximize revenue, and weaken hospitals by skimming away many of the patients having lucrative procedures, while hospitals must maintain their facilities. Many elements of health care have become a business and have adopted a business mentality, and traditional goals of community service have become endangered. The problem is not limited to hospitals or freestanding facilities. Physicians are attracted to specialties where they are not needed, in areas already oversupplied. There is a growing critical shortage of primary care and generalist physicians and providers and facilities in rural and inner city areas.

We conceptualize two levels of regulation: a “macro” level having to do with the capacity, supply or inputs to the system—basically the limits within which care is delivered; and a “micro” level—the physician-patient encounter. The College believes there is an appropriate role for regulation at the macro level, governing the supply of health resources. Government can have substantial impact on costs, in a nonintrusive way, by regulating these “inputs” to the health care system: physician supply and specialization, technology, and capital investment. Micro-level regulation of the physician-patient encounter has failed and would be eliminated under our plan.

We propose that, under federal guidelines, states and communities establish targets for the supply of health resources, expressed, for example, in terms of the distribution and concentration of physicians and other health professionals, beds, and major technologies. Setting these targets would require careful planning and attention to national resources such as teaching hospitals and specialized centers. Enforcing them would require that the targets be linked to the payment system.

The nation must develop a national health manpower policy. Of special urgency is the need to increase the number of primary care and generalist physicians. This shift will be necessary to provide for the millions of people who will gain access to care, as well as to ensure that care is cost efficient. The output of training programs must change from the current distribution of 35% generalists and 65% specialists to a balance in the profession as a whole. To achieve this goal would require major changes in how the country educates medical students and residents and how they would be paid once they move into practice. Fees must be substantially augmented for the evaluation and management services that form the core of practice for generalists, and for physicians practicing in underserved areas.

Managing Demand

Demand for services can be dampened by promoting individual responsibility. Patients must view good health as a lifelong endeavor, beginning with early prenatal care and maintained through careful habits and appropriate preventive care. Physicians must educate their patients about their diseases and the public about the benefits of health promotion and disease prevention, and funding must be available for these initiatives. In the long run, full insurance coverage for preventive services will do much to promote health and control spending.

Patients and families must understand that, in some circumstances, a diagnostic or therapeutic intervention is futile. Understanding is best accomplished in the context of a long-standing, doctor-patient relationship in which the patient is fully included in the decision-making process. The profession and public health authorities must teach patients more about reasonable expectations.

Research (13) and the experience of our members support the conclusion that a co-payment (typically, a flat payment or a percentage of the allowed fee) required of the patient discourages unnecessary services. For low-income people, however, co-payment may also discourage necessary care. We accept the need for an appropriate co-payment as a useful restraint on demand, as well as a source of revenue for the system. However, we propose the elimination of co-payments for low-income patients, so that the entire fee would be covered by insurance. For others, co-payment would be limited to a specified percentage of the fee, and subject
to an annual cap. We would hope that as both patients and physicians become more knowledgeable about medically appropriate care, the need for co-payments will diminish and ultimately cease.

Payment reform is an essential element of managing utilization. Reimbursement continues to favor procedures over careful evaluation of the patient, and high cost technology over less expensive procedures. The new Medicare fee schedule was based on the concept of equitable payment, but its implementation has further eroded payment for evaluation and management services. Until the system is restructured so that it values general medical care, incentives to overutilize procedures will continue to drive up spending.

Finally, there should be restraint on patient self-referral to a specialist or subspecialist. We propose that most patients establish a clinical relationship with a primary care or generalist physician who would refer to specialty services as needed. We recognize that some patients need ongoing care from subspecialists.

Managing Administrative Costs

The nation must recapture the billions of dollars wasted in administrative expenditures, and redirect that spending for medical care. We predict substantial savings from administrative simplification under the ACP plan. Eliminating experience rating and fee discounts and forcing companies to compete on premium price and value is likely to result in the consolidation of health insurance companies. Eliminating case-by-case review would also save money. On the public side, replacing the many current programs would save the substantial costs of maintaining separate bureaucracies and developing and enforcing divergent sets of rules.

We propose a highly simplified claims process. Providers would file claims with a single processing agent at the state level (either a state agency or a firm under contract). That agent would make payments to providers and bill the patient’s insurance plan. Patients would require only a plastic card encoded with the name of their plan and the source of the financing. We must adopt a uniform claims form, and move as rapidly as is feasible to electronic filing and computerized patient records.

Conclusions

Any proposal for change implies gains and losses for the participants in a system. One criterion of the seriousness of a plan is the degree to which it asks all parties to accept responsibility for achieving its goals. The College plan asks everyone to be responsible for ensuring access to care, improving quality, and controlling costs.

The recommendations in this paper have evolved from our philosophy on the role of a professional society that holds the public’s interest primary; from listening to our members who care for and about their patients and the practice of medicine; and from our assessment of what should and, we believe, can be done.

The key change is the acceptance of limits, both philosophically and in the reality of operating within a national health care budget. In contrast to an open-ended system, squandering resources on unnecessary care or on bureaucratic excess in a limited system means that those resources are not available for patients in need and are taken from responsible colleagues and institutions in the community. Combined with a decentralized approach to the allocation of resources, the demands of providing care for all when there are limits on spending will be a powerful force to engender cooperation among all parties in meeting the community’s needs.

Learning to live within limits will require sacrifices. For patients, limits imply that they cannot have everything they want; for providers, investments and incomes must know some bounds; for insurers and other administrators, no more micro-managing the system; and for employers not providing health insurance, an end to their free ride.

What are the gains? All patients are guaranteed coverage for all effective and appropriate services. No one is without care, and there is no second-class care. Our plan restores to physicians, hospitals, and other providers their central role in meeting the community’s health care needs. They receive appropriate compensation for all care, and are relieved of the regulatory intrusion that characterizes the current system. Government and other payers gain predictability of expenditures and limits on the rate of growth. And employers get control of their costs and a boost in their ability to compete. They also see an end to cost-shifting—the hidden tax for uncompensated care which they have paid through their private insurance premiums.

Finally, the College insists that reform must be comprehensive. We cannot modify one element of the system without affecting others. For example, expanding access to care would be a false promise if we do not produce more generalist physicians. Attempting to control costs becomes doubly difficult if we do not eliminate pressures for defensive medicine through liability reform. Comprehensive reform does not imply that all changes must be implemented at one time. Careful transition and phasing, particularly with regard to the financial impact, will be necessary under an overall strategy that relates the components and presents a clear plan for achieving an integrated system and comprehensive reform.

The American College of Physicians offers its professional and organizational commitment to the task of reforming health care. The proposal we have offered is a conceptual outline. We recognize that important and practical details must be completed. Financial projections must be developed and tested. We are prepared to adjust our thinking as our own analysis proceeds and as the public debate continues. We look forward to participating with all others to achieve universal access to care and comprehensive reform.

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References