

Commentary on Rabkin and Cook, “Health Care Crisis: Systems Insight to a Practicable Approach”

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Jon Stewart interviewed Henry Waxman in an August episode of “The Daily Show.” He repeatedly asked the Congressman why the House’s health care reform bill was over 1,000 pages and so complicated that no one could understand it. Waxman laughed, outlined the basic principles, and described a few components, but he never really answered Stewart’s question.

I have read Drs. Rabkin and Cook’s paper twice. Thankfully, it is only eleven pages long! Unfortunately, I found the piece disappointing since the aspect of reform it deals with, though important, does not address the major health reform issues facing the United States; it only nibbles at the edges.

I start with the premise that most people are troubled if not ashamed that in the most costly system in the world we have so many million people who are uninsured.<sup>1</sup> I believe, and hope others would agree, that the payment systems in place today are a major part of the problem. Rabkin and Cook propose a new paradigm — a staged approach to restructuring the organization, delivery, and financing of the U.S. health care system through a new Medicare product offering. Strong incentives would be offered to encourage primary care teams to be formed and then utilized by Medicare beneficiaries. Other incentives would attempt to control the total costs of care and improve the quality of care and patient satisfaction. Rabkin and Cook call this approach “Balanced Incentives for Health.” The “teams” that are created would compete with each other and could evolve into and function as a “medical home.” A capitation system and global budgeting

are central to their proposed approach. Further, they allude to the expansion of their program to the Medical Home approach now being promoted in the United States. Like the Centers for Medicare and Medicaid (CMS), their program is physician-centric and “utilizes” other health care providers, including (or should I say especially) nurses. The authors lean heavily on Enthoven’s original work on competition,<sup>2</sup> which did not work, and the Kaiser-Permanente system, which was in desperate trouble just eleven years ago but now is seen as a model capitation program.

Not only do the authors fail to discuss the many factors impeding primary care practice among physicians, but they do not take the leap of recognizing that nurse practitioners should be central to any reorganization plan, especially given their ability to deal with collaborative systems, to care for our elder populations, and to implement preventive measures for health care.

Most disappointing to me, however, was that these esteemed authors fail to address or even mention the larger problems that the reform proposals are trying to confront. Equally important, they do not offer a roadmap to weaken the power of those who have prevented previous efforts at reform. On August 14, 2009, *The New York Times* reported on a coalition of pharmaceutical companies, organized medicine, and hospital associations that is supporting the Obama plans, but the private insurers and the politicians who support them and are supported by them would have you believe we will be doomed (literally) if these plans are enacted. Currently, criticism against reform is being conducted as a play-by-the-book method at forums taking place on health reform. Rather than criticism being one of the most wonderful intellectual exercises that we revel in, it has become a planned, orchestrated shout fest to protect past failed systems and, specifically, the for-profit mode of health care, and it is used to attack the President for spurious and potentially dangerous reasons.

I am disappointed with Rabkin and Cook’s new paradigm for several reasons. *First*, it deals only with Medicare. Although this is a wise approach since solutions such as theirs can be implemented with or without health reform, I would have liked to have seen a glimmer of ideas stemming from what we know of the current bills being discussed; specifically, the notion of a health insurance exchange. But most important, I would have welcomed some ideas for dealing with the most important principle of reform

— universality. While there seem to be several excellent ideas in these reform proposals, I wonder why we feel we must reinvent the wheel. Both Germany and France have public-private health care for all, which their citizens adore. Some adaptation of these models is certainly feasible for the United States. For example, addressing what President Obama refers to as Cadillac care, in Germany about 10 percent of the population has private commercial insurance, where they share the same health care delivery system but enjoy more amenities.<sup>3</sup> The subject of universal care in this country has never been presented fairly or compellingly.

*Second*, management of care, an important component of Rabkin and Cook's paper, is vital. But to have a healthy citizenry we must be able to expand access to care to the entire community. To do this, our health care system must manage care in order to provide basic benefits to all. When a system is grounded on the principles and philosophy of care rather than of profit, it can provide the framework where providers are able to look at the whole patient and the trajectory of needs across the life span: from prevention to care during acute illness, to rehabilitation and convalescence, to wellness, through chronicity and eventually to death. I believe that smaller, regionally based not-for-profit health care organizations can ultimately offer a sound basis for organizing a new system.

*Third*, we must strengthen the power of the users of health care. Today the real buyers of health care are the government and the corporate purchaser. For the individual or the family to have clout they must learn to influence the buyers through the ballot and the negotiating table. As I mentioned earlier, some of the public has been influenced by the self-righteous radical reactionaries, who have prevented reform in the past and seem well on the way to preventing it now. But at the same time there are now strong broad-based coalitions for universal health care (Health Care for America Now). The single-payer system (disclaimer: I am very much in favor of this system) has never caught on with the American public, including most health professionals, despite having superb advocates. Coalitions have become more acceptable when they are flexible and when they strengthen the current system with a public plan.

*Fourth*, we must challenge the overwhelming power of health insurance companies and some pharmaceutical companies that have skewed congressional thinking for more than half a century away from a universal, government-sponsored health care

system. We must support and strengthen the efforts of nurses, doctors, and other clinicians who have joined with one another and with patients to regulate the current system.

*Fifth*, I have been a nurse for 60 years. Many times I and others have said that this is nursing's moment, or that nursing is at the cusp of its maturity, or that the window of opportunity is open for nursing now, or that nursing is the right answer to the public's needs. All of these statements and others were correct but the moments passed or important conditions such as unrestricted practice and independent reimbursement were not in place. But now, for the most part, these conditions are in place and the problems that persist in health care cry out for nursing solutions. In fact, there has never been a time in our history when the knowledge and skills of nurses have been such a perfect match with the health care needs and desires of U.S. citizens.

Recently we have become sensitized to the problematic rehospitalizations occurring with the older population. Nurses have been at the forefront of transitional care research and practice.<sup>4</sup> Nurses have emphasized the importance of providing high-quality care *coordination* to chronically ill and frail elders. Nurses have emphasized providing access to affordable basic health care in the home, in the schools, and in the workplace. Yet, nurses are not included as primary providers and leaders of medical homes in any of the reform proposals. Although they are identified as adjuncts to care in the Rabkin and Cook paper, they are not described as team leaders or direct providers.

I admit that my disappointment in the Rabkin and Cook approach does not deal with the small step they have proposed. Rather I believe that their small step should have been couched in the general principles of a broader health care reform proposal. Any reform program must maintain a focus on our common purpose of improving health care for all, incrementally, of achieving high-quality care relative to the investment (ROI), and of having strategies in place for a cohesive and coherent system. Such a system would include: primary, secondary, and tertiary care over the lifespan; programs for prevention of disease; building people's capacity for self care (but not confusing that with asking them to nurse and doctor themselves when they are really sick); assuring transparency of information about health and health care to empower individual citizens; helping them

understand and use that information; and guaranteeing accountability of all providers and modalities of care.

It is naive not to recognize how much of our future depends on the quality of the health care system. If we and our fellow citizens are to get the necessary care, and if those of us who are clinicians are allowed to give it, we have to have the courage to shatter the American taboos about the market and universal coverage. I would have liked Drs. Rabkin and Cook to deal with these larger questions. Our health care scene is fluid and changing. It is set in sand, not in stone. This is a perfect time to influence change that builds on our sense of community and strengthens our capacity for citizenship.

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<sup>1</sup> “How Many Americans Will Be Uninsured By 2010?” *Health Affairs* 28 (4) (2009): w573-w577 (published online May 28, 2009; 10.1377/hlthaff.28.4.w573). C. DeNavas-Walt, B. D. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (U.S. Census Bureau, 2008); retrieved February 1, 2009: <http://www.census.gov/prod/2008pubs/p60-235.pdf>.

<sup>2</sup> A. C. Enthoven et al., “Redefining Health Care: Medical Homes or Archipelagos to Navigate?” *Health Affairs* 26 (5) (2007): 1366-1372.

<sup>3</sup> U. E. Reinhardt, “Global Budgeting in German Health Care: Insight for Americans,” *Domestic Affairs* (Winter 1993/1994): 159-194.

<sup>4</sup> M. D. Naylor, “Transitional Care Model for Older Adults: A Cost-Effective Model,” *LDI Issue Brief* 9 (6) (April/May 2004).