

SERIE FINANCIAMIENTO DEL DESARROLLO

**A COMPARATIVE STUDY OF HEALTH CARE POLICY
IN THE UNITED STATES AND CANADA:**

**WHAT POLICYMAKERS IN LATIN AMERICA MIGHT
AND MIGHT NOT LEARN FROM THEIR
NEIGHBORS TO THE NORTH**

Joseph White



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ABSTRACT

The purpose of this comparative study of the structure and operation of the health care systems in the United States and Canada is to draw lessons from those experiences that may be relevant to the countries of Latin America and the Caribbean.

First, the study examines the different sources of health-sector funding in the United States and Canada and the levels and types of coverage provided. The fact is brought out that per capita levels of expenditure in these two countries exceed per capita national income in much of the region. A comparison of the two systems shows that, although expenditure is lower in Canada, its coverage is better.

Second, the author discusses the different methods of payment that have been implemented in conjunction with regulatory and supervisory instruments and institutions. In Canada, responsibility for health-budget performance lies with the provinces, and transfers from the central government are made, *inter alia*, through a capitated payments system. In the United States, a number of different payers, each with its own individual cost control mechanisms, are found. It is argued that selective outsourcing of health-care services in the United States would appear to be less relevant for Latin American countries than the Canadian system of payment, given the need to increase the levels of coverage in these countries.

Third, the study focuses on proposed health care reforms in the two countries. One of the main objectives of these reforms is to curb rising costs.

Lastly, the author draws a number of conclusions which he considers relevant to the needs of Latin American and Caribbean countries. The assertion is made that the Canadian system offers advantages in terms of the provision of affordable health insurance for all.

INTRODUCTION: HOW THIS REPORT MIGHT BE USEFUL

Whether the health care policies of the United States and Canada provide useful guides for policymakers in Latin America is not an easy question to answer.

The United States and Canada are rich by the standards of modern life or human history. There is no doubt that each country could pay for an advanced standard of health care for all its citizens without sacrificing other vital national needs. That Canada does and the United States does not is simply a matter of political choice.

In much of Latin America, however, per capita national incomes are less than what Canada and the United States spend, per capita, on health care: about \$1860 in Canada in 1994¹ and about \$3,510 in the United States.² Even the best policies are not likely to buy for any Latin American economy all the services, with all the features, that even a constrained Canadian or American system would purchase.

Canada and the United States have large, established infrastructures of medical-services-providing buildings, machines, and human capital. For these countries it is possible to argue that development of health care capacity can be slowed, or even pared back, without having to sacrifice "necessary" care (however "necessary" is defined). In much of Latin America, however, there are severe shortages of the materiel and skills needed for health care. Restraint on the capacity of the system means that already gaping inadequacies will get worse.³ Thus the stakes of "cost control" are very different.

Parallel to these differences, the United States and Canada have, with rare exceptions, well-functioning systems of sanitation and environmental health. It is not necessary to consider whether the latter must be fixed before individuals' diseases could be treated. By contrast, to argue that some countries or regions of countries in Latin America should invest in sanitation rather than in disease-care is intellectually defensible both because the environmental conditions are bad enough to present a clear and immediate danger,⁴ and funding is limited enough to make financing both very difficult.

These differences mean that one whole theme of health policy-making debate is more relevant to much of Latin America than in Canada and the United States. It is true that, everywhere, advocates of public health argue that it receives too little and the "medical model" receives too much. In the United States and Canada, as in all other rich countries, budgeteers and others who for whatever reason want to restrict the medical sector assert that it is a relatively inefficient form of expenditure, and public health would be a better investment. Yet much of the public health spending that is clearly appropriate has already been done in the United States and Canada; the practical range for tradeoffs between public health and the medical model is much more limited than it is in Latin America.⁵

This report therefore is about treatments for medical problems. It focuses on how those treatments are delivered to individuals and paid for: systems of medical care and finance.

The underlying differences in wealth between Canada and the United States on the one hand, and Latin America on the other, mean that one has to be very careful about inferring that how a given measure works in the former will be replicated in the latter. Yet this report may provide some information about specific measures. The common discussion of "managed care," for example, might be improved by considering the variety of measures that go by that name. The United States is a discouraging natural experiment in the consequences of voluntary insurance that allows insurers to sort potential beneficiaries, and beneficiaries to sort themselves, with lower prices for lesser risks. Canada provides indications both of how to control spending on physician care and the politics that result from such controls.

Because the United States and Canada are only two countries, they do not provide evidence on some questions: for instance, regulation of separate, non-governmental but non-market "sickness funds."⁶ As two countries alone they cannot "prove" any positive proposition (though they can create doubt about some).

Yet looking at the United States and Canada has two main values. First, it may correct misinformation about lessons from the US especially. Second, the comparison between the US and Canada may provide information about causal relationships, and this information, even extracted from the US and Canadian contexts, may be relevant in other countries.

This text will take more space to describe health care arrangements in the US than in Canada. The reason is not that the former is a superior model, but because the American health care system is much more complicated. It is also the most expensive in the world, with the most unequal insurance coverage in the advanced industrial world. Canada, a country that in many ways is quite similar to the United States, has for many years seemed to have a superior health care system on many dimensions. A key question for this report, then, is how and why Canada has done better than the US.

As each country's health care system faces demands for greater cost control, each has come under fiscal stress that raises fears that the quality of health care will decline. It is too early to tell what the actual effects in each country will be. But what is most striking right now is the great extent to which different theories of overall organization of finance disguise underlying similarities in cost control activities between the two countries.

In the United States there is a lot of talk about markets, and the earnings of health care providers are squeezed by the terms of **selective contracts** by competing health care payers. Each payer seeks better terms; from the providers' perspective, government payers to a great extent are just bigger, more powerful payers that can demand even better terms. In Canada, by contrast, the payment of hospitals and physicians is on much the same terms for all patients, because there is a single payer, the provincial government, for the vast majority of the business done by any hospital or physician. This system of **coordinated payment**, as opposed to selective contracting, allows a different kind of politics of protest, more uniformity, and different distributional consequences than occur with selective contracting.

Yet at the levels of both the physicians and the hospitals trying to cope with constraint, and the payers trying to justify it, one sees much the same arguments and behaviors. In each system the payers claim there is too much hospitalization, and services must be shifted to an "outpatient" or "community" basis. In each system therefore hospitals are losing beds, being closed or merged. In each there is talk that care will be both improved and made more efficient through processes of "integration" — though in Canada through "regionalization" while in the US through "HMOs". {I

have put those expressions in quotations because they are used frequently but neither has any meaning beyond being a positive-sounding label}. In each there is an effort to switch responsibilities to providers with less training: from specialists to general practitioners, physicians to physician assistants; registered nurses to lesser-trained nurses or nurses' aides. In each there is talk of making each incident of care more appropriate, but a lot more action to simply squeeze the income of providers. In short, while the theories of the **method** of overall cost control might be different, the **objects** of cost control — what is actually targeted, with what likely consequences — are much the same.

And, in each case, it is simply very difficult to say that the methods being used avoid the risk that care will indeed suffer from fiscal constraints. Objectively, the data just is not strong enough to judge effects from cuts in either system. Anecdotally, complaints identify much the same difficulties in each system — particularly worries about the quality of care in hospitals. Hospital staffing and facilities are constrained but the average patient per bed becomes sicker and sicker, as more services are performed outside the hospital and patients are discharged more quickly.

Another lesson from this comparison, therefore, might be to be very cautious about believing that some method of cost control can save money without attacking some objects of control that we value; and to be cautious also about believing that any method can make easier the hard choices about which objects within health care to try to control.

Yet that uncertainty does not apply to the other main dimension of health care policy, which is the extent and equity of access to care. On that dimension the differences between Canada and the United States remain stark and, in spite of some rhetoric, neither country is substantially altering its methods. Canada guarantees decent insurance to all citizens; the United States does not.

In analyzing these differences, the first chapter of this report will provide data for each country about the extent and type of insurance coverage, sources of funds, health status in comparative perspective, and the supply of medical services. As part of that chapter we will review information on the distribution of services in the two countries.

The second chapter will focus on how medical providers are paid for their services, and thus on how payers try to control costs. Both ends of these processes are far more varied in the United States, with its multiple and competing insurers and its "managed care" organizations. But this especially is a subject for which the US/Canada comparison should be useful.

The third chapter will discuss current reform debates and activity in each country. This presents two difficulties. First, the most recent proposals must be distinguished from action. In Canada as in many countries discussion of "pro-competitive" reform far exceeds achievement. Second, some events are hard to measure and harder to explain. Health care cost increases have moderated significantly and even reversed in California since 1993, but nobody really knows why. The generalizations drawn in this chapter should be considered more tentative than those that are based on more permanent trends, as in Chapter Two.

In concluding this report, I will make my own attempt to draw lessons for Latin American policymakers. Some of this will consist of generalizations based on my broader work on health care finance and delivery in the wealthier OECD nations.⁷ Some will be my own speculations about how US and Canadian lessons might apply in nations with different histories and much less wealthy economies. I will not insist on the accuracy of those speculations, but they may serve as a starting point for discussion.

Endnotes for Introduction

¹ In Canadian dollars the figure was \$2,478; I have converted the currencies at roughly 75 cents U.S. per Canadian dollar. Health Canada, "National Health Expenditures in Canada 1975-1994: Highlights" Policy and Consultation Branch, Health Canada, January 1996 (p.5).

² Katharine R. Levit, Helen C. Lazenby, and Lekha Sivarajan, "Health Care Spending in 1994: Slowest in Decades" *Health Affairs* 15:2 (p.138).

³ See, for example, Pan American Health Organization, *Health Conditions in the Americas* (Vol. 1) pp.7-8, 339-53.

⁴ Ibid, pp. 404-05.

⁵ A full discussion of the reasons I make this statement would be beyond the scope of this paper. But the key points are as follows. First, the key effective interventions, such as clean water or immunizations, are known and basically already done. Where the U.S. falls down on these matters, as in immunizations, it is disgraceful but not a matter of large missing expenses. Second, there are many matters that sound useful but nobody knows how to do: such as "education" that would significantly alter rates of pleasurable or addictive behaviors. Third, much of the "public health" agenda that involves greater income equality is a matter of much greater public dispute than the limited redistribution involved in subsidized health insurance. Last, there are a number of "public health" measures that, while they might well improve public health, and we even have some idea how to do them, would not save money. Thus reducing smoking with much higher taxes would not save money for the health care system because smokers are pretty cheap: they contribute for most of a normal working life and then consume services for less than the average retired life.

⁶ Another difference has to do with relationships between physicians and hospitals: Canada and the United States rely largely on "admitting physicians" who have practices outside the hospital, while most countries staff hospitals to a much greater extent with salaried doctors. In addition to the conference contributions by Professor Wasem, readers in search of information about sickness funds might also consult Joseph White, *Competing Solutions: American Health Care Proposals and International Experience* (Washington: The Brookings Institution, 1995) and especially William A. Glaser, *Health Insurance in Practice* (San Francisco: Jossey-Bass, 1991).

⁷ See in addition to *Competing Solutions*, Monique Jerome-Forget, Joseph White, and Joshua Wiener, eds., *Health Care Reform Through Internal Markets: Experience and Proposals* (Montreal and Washington, IRPP and Brookings, 1995) and Joseph White, "Markets, Budgets, and Health Care Cost Control" *Health Affairs* 12:3 (Fall, 1993) pp. 44-57.

1.- COVERAGE AND HEALTH IN CANADA AND THE UNITED STATES

Throughout the advanced industrial world, most health care is not paid for by individuals out of their own pockets at the time of service. Instead, health care is paid from systems that I call "shared savings." People contribute according to some set of rules, and consume services financed by this pool of contributions. There are four basic methods:

- 1) Taxes can finance government organizations that provide services: **public provision**.
- 2) Taxes may finance government insurance agencies, that in turn pay for services purchased from either public or private providers (mainly the latter): **public insurance**.
- 3) Government may require contributions to nongovernmental insurance organizations, that either reimburse or directly provide services to individuals: **sickness funds**.
- 4) Private firms may sell insurance on the open market to individuals, which in turn may either reimburse providers or pay for some system of direct services by a limited network of providers: **private insurance**.

These categories allow, of course, for some intermingling. Government may encourage private insurance with a number of subsidies, and constrain it with regulations. Whether mandatory sickness fund contributions constitute a "tax" is in some ways a theological issue.⁸ The American "Medicare" program has attributes of both public insurance and a sickness fund. I am also submerging, in this typology of finance, differences in systems of private delivery: private insurance might pay for either fee-for-service or capitated care. Yet the basic distinctions are important for understanding how health care finance in the United States and Canada differs from in most Latin American countries.

From the standpoint of this typology, both Canada and the United States are quite unusual compared to other advanced industrial nations. Canada relies far more on public insurance. The United States relies far more on private.⁹

1.1.- Canadian Financing

Each of the ten Canadian provinces serves as primary health insurer to its citizens. The provincial insurance is paid for by a mix of federal transfers that slightly favor poorer provinces, general provincial revenues, in four cases employer payroll taxes, and in two

cases premiums paid by beneficiaries. Where provinces have such dedicated financing, it is always only a supplement to the bulk of financing, which is from provincial and federal general revenues.

In order to receive federal funds, the provinces must meet the terms of the Canada Health Act. The Act requires that provincial insurance be:

- **Comprehensive:** covering all medically necessary services provided by physicians;
- **Universal:** providing coverage to all legal residents of a province (with a three-month waiting period);
- **Publicly administered:** either directly by the provincial government or by an authority directly responsible to it;
- **Portable:** so beneficiaries would be covered when away from their home province or, if they moved, until they became vested in their new province's plan; and
- **Accessible:** which means that there be no financial barriers to access, which in turn means that there be no extra billing to patients above the fees paid by the provincial insurance. A province therefore is liable to forfeit federal funds in the amount of any extra billing that it allows.

In 1995, federal transfers paid 32 percent of the cost of provincial health insurance. That figure, however, has been falling steadily as the Canadian government seeks to reduce its budget deficits: it was 41 percent in 1977. And large further cuts are planned.¹⁰ The federal government transfers very similar amounts per capita for health care costs to each province. But, since incomes and thus costs are lower in the poorer provinces, this transfer pays a somewhat larger share of the health care bill in the poorer provinces.¹¹

Even before 1996, therefore, there was some concern that at some point some richer provinces' governments would no longer be receiving enough of their budgets from the federal government to make the national standards enforceable. Ironically, the provincial cuts in 1993-94 were so severe that the federal share of spending actually grew. The federal spending cuts enacted in the 1996 budget cycle, however, restored the worry that federal influence would diminish with federal dollars.¹² Nevertheless, the structure described here represents the "Canadian model," as it has operated for the past three decades.¹³

Each provincial health insurance plan insures all "medically necessary" physician and hospital services. In practice that is defined as anything a hospital can do unless it is specifically excluded, and anything included on each province's physician fee schedule. Beyond this core, provincial benefits differ. Most provide some assistance for pediatric dentistry and cover in-hospital oral surgery. Coverage of optometry, chiropractic, and physical therapy varies. No province covers such "luxuries" as elective cosmetic surgery and private rooms. Nursing home benefits (and supply) vary; in general the provinces support health services but not necessarily room and board.

Every province has a separate pharmaceutical benefits plan. Normally, these provide much greater benefits for seniors, disabled persons, and the indigent. These plans pay for approximately 40 percent of the prescription drugs that are not dispensed in hospitals (hospital provision being part of the hospital budgets). The

provisions of the Canada Health Act that ban costsharing do not apply to these separate pharmaceutical benefits.¹⁴

One of the basic provisions of Canadian health insurance is that it is not legal to sell private insurance for the same benefits as are covered by the public insurance plans. For-profit private insurance is, however, a common supplement to the public plans. An estimated 80 percent of the population has private cover for items such as private rooms, pharmaceuticals, and dental care, financed primarily through employers. The Canadian tax system, as in the United States, favors employer-provided insurance by allowing employers to count it as a business expense, rather than treating premiums as income to the employees.

A few doctors practice entirely outside the public insurance schemes, so serve a patient population willing to pay out of pocket the entire cost of services. There has been some development of private clinics in urban areas. The National Forum on Health reported that, "most of these parallel, privately-financed services fall into two categories — access to technology and high-volume/short-stay surgery." A patient may, for example, obtain an MRI scan without referral by paying a fee as high as \$1,000. "Other clinics offer same-day surgery procedures, such as cataract removal or arthroscopic surgery, as private transactions."¹⁵ To the extent such clinics are entirely separate from the basic insurance system, so collect no money from it, they are not so controversial. It is another matter if the clinics try to collect the insurance system's fees and then charge a further, extra amount to patients for the faster service. The federal government in 1995 held Alberta in violation of the Canada Health Act for allowing such extra charges. After some resistance, Alberta finally agreed to stop allowing those charges.¹⁶

As in any country, a portion of Canadian health expenditures are financed outside of both the private market and the insurance system: for example, as municipal services, or direct federal government payments for soldiers, or as part of compensation schemes for workers' injuries (Workers' Compensation). In 1994 Canadian health care finance could be divided as in Table 1.

The majority of Canadian private sector health dollars is spent on pharmaceutical care and "other professionals", as would be expected given the gaps in the public insurance.¹⁷ The private sector share of spending, which was fairly stable from 1975 to 1984, grew from 23.8% in 1984 to 25.4% in 1991 and then, with the restraint in Canadian public sector spending after 1991, to 28.2% in 1994. Since much of the cost controls in Canada have focused on prices rather than level of service, and the major portions of private sector spending have not been subject to the same price restraints, that does not mean that the private share of health services has been increasing as quickly.¹⁸

In Canada as everywhere else, the elderly are more likely to incur medical costs. The 11.9% of the population age 65 or over incur 38.7% of the total costs. They consume an even larger share of the public dollars, 49.3% in 1994, in part because of their more generous pharmaceutical benefits.¹⁹

Canada's provincial health insurance schemes pay for care for virtually every legal resident of the country. In each province there are few if any confusions about eligibility, and everyone's insurance covers them under the same terms. It therefore might be considered more egalitarian than the schemes in countries like Japan, where costsharing varies with kind of employment, or Germany, where some differences in payment rates associated with different sickness funds and with private insurance provide some incentives for physicians to favor certain patients. Where Canadian

benefits are more limited than in Germany or Japan (e.g. pharmaceuticals), they actually favor the poor.

1.2.- United States Financing

1.2.1.- Levels of Insurance and Benefits

A health care finance arrangements, by contrast, are a hodge-podge of national government programs, federal-state programs, and private arrangements.

There is conflicting data as to what percentage of the US legal resident population has health insurance at any given time. Rates for persons age 65 and over are not hard to figure. Over 96 percent of Americans of that age are covered by the federal Medicare program, and the great majority of those who are not are still covered by the private insurance they had when they were younger.²⁰ Estimating insurance for the nonelderly is another matter.

The figures that are usually used are based on the Bureau of the Census Current Population Survey (CPS) taken in March of each year, which asks about coverage during the previous year. Of the approximately 259.3 million civilian, noninstitutionalized Americans in 1994, 228.1 million were nonelderly. A person might have been covered for part of the year and uncovered for another part. So it is likely that some who report no coverage actually had some for part of the year, but also that fewer people report having been uncovered in the previous year than actually had a period without coverage during that year.

The March, 1995, CPS produced an estimate of 39.4 million uninsured nonelderly Americans in 1994. But that survey also, for the first time ever, asked whether respondents were insured **at the time of the survey**. Having made a series of adjustments to the data, the Employee Benefit Research Institute reported that, "approximately 61.2 million nonelderly Americans (26.8 percent) were uninsured during the reference week in March 1995". That is a lot more than either the 39.4 million figure or analyses based on the same survey in previous years, that had concluded about 50.7 million people were uninsured for at least a one month period between 1991 and 1993.²¹

A more recent study with a much smaller sample size estimated that 37 million adults were uninsured at some time in 1995 — which must mean a much larger number of people once one includes children.²² How these various figures can be reconciled is not entirely obvious. For example, if the CPS surveys were to be believed, they suggest that 19.5 million nonelderly Americans had insurance in 1994 and yet were uninsured during a week in March, 1995.²³ Is it really likely that roughly an eighth of the nonelderly population lost insurance between 1994 and a week in March of 1995? Or that so many more people could be uninsured for a given week than for as much as a month over a 32 month period?

The survey data does point to some evident truths about the US health insurance system. First, at any point in time a far larger proportion of the public than in any other advanced industrial nation is uninsured. Second, insurance is far less secure in the United States than in those other countries. Because specific plans are linked to specific employers, or have waiting periods, or for other reasons, it is relatively easy for an American who moves or changes jobs to be without insurance for a short period of time. Third, there are survey response problems because it is easy for an American

to be unsure about his or her insurance status.²⁴ Fourth, there ought to be more Americans who are uninsured for a given short period of time (e.g. the past week) than a longer time (the past month, or the past year). The estimate that 23.7 percent of the population was uninsured for a week in March is not really out of line with a 1991 estimate that 20.3 percent were uninsured for a previous month, and 7.0 percent for the previous year.²⁵ And the point-in-time estimate certainly does not suggest that the more traditional estimates understate the security of health insurance in the United States.

It seems safest to say that in 1994 at least 39.4 million Americans were without health insurance for what we'll call a substantial amount of time. That is 17.3 percent of the nonelderly and 15.3 percent of the total civilian noninstitutionalized populations, and may be compared to one percent or less in the other major rich countries of the world.

From 1989 to 1993, the CPS data estimated the proportion of Americans without health insurance rising from 14.3 to 16.1 percent. The 1994 figures show a drop in the proportion of uninsured. While one might expect an improving economy to make private health insurance more accessible, changes in question wording also "appear to have had an effect on responses."²⁶ Given that underlying trends that are believed to explain a decline in private insurance continue, it is probably safest to conclude that the actual proportion of uninsured Americans is no lower than that given in the traditional March, 1995 CPS survey, and that private insurance at least is not growing.

Americans receive insurance from a mix of private insurers and public programs. The main public programs are Medicare, a federal government program for the elderly and some disabled persons, and Medicaid, a joint federal/state program for the poor that also fills some gaps in Medicare.

Generalizations about the benefits provided by American health insurance should be treated carefully. It is fair to say that Medicare's extent of coverage would rank fairly low among plans provided by large employers, and perhaps just below the median among all private plans. Most private plans, for example, have some pharmaceutical benefits while Medicare does not.²⁷ But Medicare's costsharing is much less in practice than in law, while Medicare beneficiaries also have wider average choice of provider than in many private plans. Conversely, private insurance benefits look less generous than Medicaid's, but supply factors mean that the benefits through private insurance are more credible.²⁸ Compared to Canadian public insurance, American private insurance benefits on average are wider (e.g. cover pharmaceuticals) but have more burdensome costsharing (since Canada has none). Americans with good private coverage will have better benefits than are provided through the Canadian public schemes, but most Canadians also do better, through their supplementary coverage.

The major difference between American and Canadian health insurance benefits, of course, is that the USA has far more people without benefits. Yet the proportion of American health care costs paid out of pocket has fallen continually. It fell even as the share of Americans without insurance rose from 1989-93. In 1994, only 18.9 percent of American health care costs were paid out of pocket, the smallest share ever.

One reason is, the increase in managed care plans reduced costsharing. Managed care plans tend to disallow any extra billing and require only small copayments. Policies that restricted extra-billing in Medicare, and the growing proportion of doctors who accept the program's payment as payment in full, also reduced out-of-pocket payments.²⁹ Even though the percentage of Americans with

insurance was declining, insurance for the most expensive populations, the elderly and disabled, expanded through demographic growth in Medicare and Medicaid. Perhaps most important, people without insurance may not pay for health care out-of-pocket; instead, they may either do without care or go to the hospital and become a bad debt.

The fall in the share of hospital costs paid out-of-pocket therefore does not contradict concerns about availability and affordability of care based on declining rates of insurance. We should also remember that as costs rose, even if insurance rose more quickly than out-of-pocket payments, the latter could (and did) rise more quickly than incomes. Nor do these figures adjust for employees being required to pay a larger share of their premiums. Therefore the immediate burden of health care costs on individual Americans has been rising even as the aggregate out-of-pocket expenditure has declined.

1.2.2.- Public and Private Payers

a) Public Payers

Although most Americans receive health insurance through private market transactions, over a third of total personal health care expenditures are paid for by two public insurance schemes, Medicare and Medicaid. Other government programs, such as for veterans and for military families, raise the total public share of US health care spending to over 44 percent.³⁰

Medicare has two parts, "Hospital Insurance" (HI) and "Supplementary Medical Insurance" (SMI). Medicare HI is automatically available to all persons age 65 or over who have met the standards for participation in the Social Security system (essentially, ten years of covered employment for themselves or a spouse). It also includes persons under age 65 who are legally disabled, of whom one especially expensive group is those with kidney failure (End Stage Renal Disease). In 1995 the HI program covered 33 million aged and about 4 million disabled beneficiaries. SMI is a voluntary program but, since it charges a premium of (depending on recent Congressional decisions) between 25 and 30 percent of actual program costs, and premium costs are subsidized for many of the poor, virtually everyone who does not have coverage paid by some other source buys into SMI. Elderly individuals who do not qualify for HI also have the option to buy that insurance at a community-rated premium.³¹

Medicare's benefits are, by international standards, relatively limited. It covers all medically necessary hospital and physician care, plus certain benefits that may be viewed as alternatives to hospital care, such as skilled nursing facilities after a hospital stay, hospice care, or home health visits as part of a physician's treatment plan. But Medicare provides no pharmaceutical coverage (save for drugs provided in the hospital), nor nursing home coverage except as incidental to hospitalization.

HI's hospitalization coverage also has limits. The program defines a "benefit period" as lasting from the beginning of hospitalization to when one has been out of the hospital or a skilled nursing facility for sixty concurrent days. During that benefit period, the program will pay for up to 90 inpatient days. For the first sixty days, the only costsharing is a deductible (\$736.00 in 1996). For the next thirty days, patients would pay a copayment (\$184 per day in 1996). After the 90 days end, a patient may use his or her "lifetime reserve" of sixty days, with a higher copayment (\$368 per day in 1996). After 150 days (or 90 if the lifetime reserve was used in a previous illness), benefits expire. If a person moves from the hospital to an extended care facility, there is no costsharing for twenty days, a copayment (\$92 per day in 1996) for each of the next eighty days, and then benefits expire after 100 days.³²

The SMI program pays most bills according to a fee schedule. It pays eighty percent of that amount, and beneficiaries can be billed by their physicians for the difference. Physicians also have the option of "accepting assignment," in which case they bill Medicare directly for the 80 percent and accept that as payment in full. By 1993 physicians were accepting assignment on 93 percent of claims. Extra billing by physicians beyond the fee schedule is legal only under very limited circumstances, and only to 115% of the fee schedule. By 1993, therefore, legal extra billing accounted for only \$0.4 billion in charges under SMI. Physicians' willingness and ability to charge patients any costsharing seems to be related to market conditions: in 1993 99 percent accepted assignment in Massachusetts, which has lots of doctors, but only 54% accepted assignment in South Dakota, a rural state with much lower physician/population ratios.³³

Since almost 70 percent of elderly Americans have some sort of private "Medigap" insurance, another portion have extra support from Medicaid, and physicians accept assignment for such a high proportion of charges, Medicare's costsharing does not prevent coverage. But a person with a truly catastrophic illness clearly has less coverage than in other nations' systems, which have no such limits on total hospitalization. Over \$9 billion in costsharing for HI alone in 1995 at least explains the attraction of Medigap plans.³⁴ The average cost-sharing liability for those beneficiaries who had any services at all in 1993 was \$777 per person. About half a million persons incurred costsharing of \$5,000 or more.³⁵

Medicare is financed through two "trust funds," one for HI and one for SMI. Although there are plenty of complexities in Medicare's financing and accounting, basically HI is paid for by a payroll tax on current workers and employers;³⁶ SMI is paid mostly from federal general revenues and a portion from individual beneficiary premiums, which are aided for the poor by state contributions through Medicaid. Employees and employers each pay 1.45 percent of total payroll to the HI fund; self-employed persons pay 2.9 percent.³⁷ Thus Medicare HI is a peculiar amalgam of sickness fund and government insurance principles: it is paid for by payroll contributions, but not by the beneficiaries!

Since virtually everyone covered by HI is also covered by SMI (and vice versa), the distinction between the two funds is less than realistic. That has become even more true as some benefits that were once delivered in the hospital have moved out of the hospital (such as outpatient surgery), only still to be paid out of the HI trust fund. In practice it makes most sense to view Medicare as a whole, financed by a mix of payroll taxes (more than half), general revenues, and beneficiary premiums. But the trust fund device provides a focus for political debate about cost control, for good or for ill.³⁸

Medicaid is a program for medical insurance for the poor, administered by the states and funded by a mix of federal and state funds. For most of its approximately 35 million beneficiaries in 1995 Medicaid was the primary insurer; however, its benefits also include supplementary payments to Medicare beneficiaries.³⁹ Thus state Medicaid programs will pay individuals' Medicare premiums plus extra Medicaid benefits for any Medicare-eligible person who meets that state's Medicaid eligibility standards. States are also required to pay Medicare premiums and costsharing for any Medicare-eligible person whose income is below the federal poverty level but above the state's income cap for Medicaid eligibility.⁴⁰

As the last provision suggests, Medicaid is not in fact available to all persons whom the federal government defines as "poor" (which was an income of \$11,890 for

a family of three in 1993). It covers about one-half of all Americans living in poverty.⁴¹ Instead, Medicaid eligibility is a mix of national requirements and state options.

The requirements include children from families that receive cash payments under the federal/state Aid to Families with Dependent Children (AFDC) program. But many states refuse AFDC coverage to families with incomes far below the federal poverty line. Medicaid further requires that states cover pregnant or postpartum women, and children under age 6, if their family incomes are 133 percent of the poverty level or less. Moreover, all children who were eligible and born after September 30, 1983 remain covered until age 19 if their family income is below the poverty level. States also must cover the disabled persons who receive federal Supplemental Security Income (SSI), the various Medicare-eligible populations, and various other groups.

In addition to these mandatory categories, many states provide aid in optional categories, to which the federal government contributes on the same terms. These include among others pregnant women and infants up to 1 year old with incomes more than 133% but less than 185% of the federal poverty level; some aged or disabled adults who are not on SSI; and people whose medical expenses are so high that, after those costs, their incomes would be lower than the relevant poverty standards (the "medically needy"). Within this complex set of terms some of the most controversial involve the conditions under which the elderly will receive Medicaid support for nursing home expenses. Basically they must spend (or otherwise make invisible to the government) almost all assets other than a house.⁴² Therefore in the United States government support for long-term institutional care for the elderly is as a stringently means-tested benefit rather than a universal entitlement.

The benefits that Medicaid promises to cover are quite generous. Among the mandatory benefits are inpatient and outpatient hospital services, laboratory and x-ray and nursing facility costs, physician services, medical and surgical services furnished by a dentist, transportation for those unable to transport themselves to health care providers, home health nursing and family planning services. Optional services include other medical and remedial care if recognized in state law (such as podiatrists and chiropractors); physical, occupational and speech therapy; dental and optometry services; prostheses and even eyeglasses. They also include inpatient psychiatric care for persons under age 21, care for tuberculosis, and a wide range of community- or home-based services for the elderly or disabled.

Almost all states provide a large portion of these optional services, for two basic reasons. First, many of these services might be affordable to most citizens but are not for the poor. Second, many are services that states were previously providing anyway. By making inpatient psychiatric care part of Medicaid, for example, a state could get the federal government to assume half or more of a previously-existing expense.

Medicaid is not, however, as generous a program as its benefits may make it seem. One difficulty is, Medicaid historically has paid significantly lower fees for services, especially for ambulatory care, than are available from other payers. Moreover, the Medicaid population, especially the mothers and children, tend to be concentrated in areas in which physicians are reluctant to practice for non-programmatic reasons (such as crime). So there has been low physician participation in the program, and some doctors who participated have only been willing to take a limited number of Medicaid patients.⁴³

The very complexity of Medicaid's eligibility categories also reduces its effectiveness. Medicaid is supposed to help only those who "truly need it." Therefore people go on and off the roles frequently. This not only reduces the continuity of care,

but means a person who is suddenly needy might first have to get on the rolls in order to get the care they truly need. The flaws in this approach were highlighted by a study of Medicaid's special eligibility for prenatal care for pregnant women; as one of its authors explained, "Women have to become aware that they are pregnant, know that they are eligible because of their pregnancy, and apply for Medicaid eligibility. That whole process may take long enough that it prevents them from getting care early in their pregnancies."⁴⁴

Furthermore, states have tended to discourage participation by limited outreach to inform people of their eligibility, and with complex application forms. In general richer and more politically liberal states (such as New York) tend to pay higher fees, have more generous AFDC programs, and seem to have fewer informal barriers to access than poorer and more politically conservative states (such as Mississippi).⁴⁵

Nor does Medicaid's spending fit the political profile of its beneficiaries. Medicaid tends to be considered part of the "welfare" system, and its spending caught up in opposition to spending on the undeserving poor. Mothers and children in poverty in fact represent over 70 percent of the population served by Medicaid. Yet those beneficiaries account for less than 30 percent of the spending. The reason, of course, is that care for the aged and disabled is much more expensive — especially in Medicaid, with its nursing home benefits. Thus in 1995 the program spent an average of \$1,728 per person in the low-income families, vs. \$8,685 per blind or disabled person and \$10,166 per elderly beneficiary.⁴⁶

A final and important way in which Medicaid is not quite what it seems involves the extent to which it is paid for by federal and state governments. The federal government is supposed to pay half of each state's administrative costs, and between half and 83 percent of its programmatic costs, depending on a formula that favors poorer states with greater needs.⁴⁷ The difficulty comes in determining how much a state is actually spending.

As noted above, states have an incentive to take any health care-related activities for which they were previously responsible and transform them into "Medicaid" expenditures. More dubiously, they have invented ways to increase their nominal contributions for hospital care without increasing their actual spending. For example, a state might increase its Medicaid payments to hospitals by an amount equivalent to \$300 million, then either tax or induce a "donation" from the hospitals of \$150 million. So the state's net expenditure would be \$150 million. But the state would then receive a minimum of \$150 million in "matching" funds from the federal government, enough to cover the entire extra payment. As a result, state taxpayers would be contributing no more than before; the hospitals would have \$150 million more; and the federal government would be paying (at least) \$150 million more. Yet Medicaid would look like it had become a \$300 million larger "burden" on the state budget! When states recognized this possibility in the late 1980s they flocked to exploit it. Congress acted to limit use of such "tax and donation" programs in 1991, but they were so large a part of state budgets that Congress grandfathered many existing provisions. "The Medellin drug cartel could learn a lot about money laundering from the states," proclaimed a former Inspector General of the federal Department of Health and Human Services.⁴⁸ As a result, while Medicaid expenses surely have grown quickly for some legitimate reasons (including legislated coverage expansions, and a growing population of elderly in need of nursing home services), neither state budget figures for Medicaid nor federal spending growth rates in the early 1990s should be taken at face value.⁴⁹

In any system of shared spending one level of government may exploit the other. Canadian provinces have legitimate complaints about the Canadian federal government's reductions in its share of health care spending. That is the danger of a system in which the national government sets its contribution and requires lower levels to pay the balance. Experience in American Medicaid reveal the contrary risks of a system in which the national government provides an unlimited "matching grant" and has little direct control of other service or reimbursement arrangements.

Other Public Payments. Aside from Medicare and Medicaid, governments in the United States pay for health care expenses in a wide variety of ways. For historic, political, and some practical reasons, the federal Department of Veterans' Affairs operates an extensive system of hospitals and other medical services.⁵⁰ "VA Med" spent \$16.2 billion in FY 1995. Military medical services and the federal government's insurance program for the families of members of the uniformed services also must be counted. A large number of smaller programs pay for special populations and services: American Indians, some federal support for vaccinations, and rural and inner-city community health clinics are examples. And the federal government, of course, also pays billions for medical research and epidemiology, centered in the National Institutes of Health and the Centers for Disease Control.⁵¹

At the local level states and especially city and county governments established systems of public hospitals long before creation of Medicaid. Many patients who historically were served at public expense by those hospitals now have their care reimbursed by Medicaid and/or Medicare. A special program within Medicaid and Medicare, for "Disproportionate Share Hospital" (DSH) payments, recognizes that some hospitals have many more patients who are unable to pay or who pay only the lower, Medicaid rates, and provides extra payments to those providers. These DSH payments in 1996 were expected to total \$19 billion.⁵² Yet this federal/state help does not relieve local governments of all the cost burdens of supporting the public hospitals. In essence, these institutions are the last resort for care for many Americans who do not qualify for Medicaid, such as the substantial proportion of uninsured poor, or undocumented aliens.⁵³

The threatened closing of Los Angeles County/University of Southern California Hospital in 1996 dramatized the role of urban public hospitals in America's health care system for the poor.⁵⁴ At present, the same budgetary and ideological pressures that threaten reductions in Medicaid and especially DSH rates also endanger state and local budget subsidies to the public hospitals and other safety net providers.⁵⁵

b) Private Payers

Most nonelderly Americans obtain health insurance for themselves through their own or a family member's employment contracts. In 1994 an estimated 64 percent of the nonelderly — 145.9 million people — were covered by employment-based health insurance. Another 7.2 percent had private insurance purchased separate from employment.⁵⁶

Both employers and individuals, when purchasing insurance, must choose among possibly hundreds of plans in a given market. They range from health maintenance organizations that provide virtually complete care with no costsharing, to "catastrophic" insurance that only covers expenses incurred above some high deductible, such as \$4,000 per year.

Many insurers may choose not to sell to individuals or groups which the insurer believes may be too risky. Examples range from loggers (whose work is very dangerous) to flower shop employees (who are believed more likely to be gay, so at greater risk of

AIDS).⁵⁷ Insurers also can charge much higher rates to such groups or persons. In some states there is a single insurer, such as Blue Cross/Blue Shield, which charges community rates: the same price to all persons within certain age categories in a given area. Any plan with community rating, however, will see its costs spiral as sicker people join it and healthier people take discounts elsewhere. Therefore retaining such an insurer of last resort requires substantial government action, which is very difficult to maintain.⁵⁸

Individuals who do not receive insurance through employment face extra difficulties. Insurers will charge them even higher per capita rates because administrative costs are higher per capita for selling to individuals. The federal government provides a smaller tax break: only 30 percent of the cost of insurance bought by an individual can be deducted from income, compared to 100 percent of an employer's payments. Individuals are even more exposed than small groups to insurers' either charging extremely high premiums or simply refusing to sell based on the customer's medical experience, such as having a chronic condition.

Moreover, health insurance in the United States is just plain expensive. In 1992 the average cost of health insurance for a family of four was over 13 percent of the average family pretax income.⁵⁹ Thus not just the price advantages of buying through a group and the higher tax-subsidy to employers but simply the extra contributions from employers help explain why much American health insurance is employment-based. Some economists would argue that such calculations are meaningless: that all employer contributions come indirectly from wages. Neither employees nor employers believe that.⁶⁰

It is no accident, then, that most American health insurance is provided through employment. In that sense, American health finance may seem similar to the approach in the sickness fund systems of Germany, France, or Japan. In fact, the systems are very different.

1) Health insurance provided through an American employer is much more part of a separate contractual relationship, unrelated to other employers' actions. There is little standardization of the benefits and terms of these contracts. Fifty states have fifty different regulatory regimes. Some plans have vesting periods before employees are covered, and many exclude coverage for pre-existing conditions. The situation is thus very different from in Germany, for instance, where a person who changes jobs will simply change who contributes to insurance rather than, in the vast majority of cases, anything significant about the coverage itself. Other countries use employment as a good way to collect money for health care; the United States is relatively unique among rich nations in the extent to which coverage varies from workplace to workplace and depends on employers' decisions.

2) American employer-provided insurance appears to involve higher payments from employers and lower from the employees than is common in sickness fund systems. Reality is more complicated.

In 1993, 33 percent of employees with single coverage and 21 percent of those with family coverage through their employers did not contribute towards the cost of premiums.⁶¹ On average employees paid 18 percent of the premiums for individual coverage, and 29 percent for family coverage — far less than the employee shares in Germany or France or Japan.⁶²

Yet the costs of health insurance through employment in the United States are not directly parallel to costs in sickness fund systems. The sickness fund systems combine insurance for families of the employed with insurance for most other

citizens, in the fund premiums. Americans pay separately for insurance for the elderly and subsidies to the poor. If we distribute the payments for Medicare and other government programs, and factor in non-employment-related insurance, we can see that in 1991 American health services and supplies were paid for in roughly equal proportions by employers, households, and government general revenues, as shown in Table 2.

So the share of American health costs paid by employers *as a group* is probably lower than the share paid directly by employers in some other countries. Yet *those employers who are contributing* are paying a larger proportion of the bill that they do see, and therefore have especially strong incentives to resent the costs. Moreover, the fact that medical services individually and in total cost so much more in the United States than in other countries, and the fact that many employers do not contribute, means that many of those that do contribute are paying much larger shares of their total employee compensation for health care.⁶³

- 3) Self-insurance is both more extensive and has a different meaning in the United States than in sickness fund systems. American employers may purchase insurance from an insurance company or "self-insure": that is, take the risk upon themselves, even if they hire an insurance company to manage the plan. In Europe, insurance plans based on one company ("Betriebskrankenkassen" in Germany) are fading because it is safer and administratively advantageous to pool risk. That is only true, however, because some advantages of separation are limited by legislation. German company funds must still contribute to the system of transfers that helps the funds that have larger proportions of the elderly. They also must provide essentially the same benefits, under much the same terms, through the same providers, as other insurers. Federal law exempts American self-insured plans from such state regulation as capitalization requirements, transfers that support funds with riskier beneficiaries, and minimum benefits.⁶⁴

This ability to escape both regulation and some overhead costs may explain why self-insurance has become a larger part of America's employment-based health insurance system in recent years. There are some issues of definition — for instance, is a self-funded plan that purchases reinsurance for expenses above a certain amount really self-funded? But the growth of such hybrids testifies to American employers' drive to free themselves from regulatory constraints. Surveys indicate that at least a majority of employers with 1,000 employees or more self-fund; well over a quarter of those with insurance through employment are in self-funded plans; and that more and more companies are choosing to self-insure for health care costs.⁶⁵

- 4) American employers are not generally part of a system of cross-subsidies that enables less wealthy companies to insure their employees. American employers and employees in a given company incur the full costs of coverage. American insurance lacks the dual subsidies that are implicit in sickness fund systems, in which firms and employees pay a share of payroll instead of a flat fee, and contribution rates are based on the entire community, rather than individual company risk profiles. In the United States each employment group is charged a rate based on its own experience, and high-wage firms are charged no more than low-wage firms. Moreover, like individuals, small employers face higher charges per capita because insurers are spreading marketing and administrative costs over fewer customers. Therefore paying for health insurance (or a set proportion of the costs for health

insurance, such as half) would be a much greater burden on low-wage employers in the United States than elsewhere.

- 5) But American employers also are not compelled to contribute to health insurance costs at all.⁶⁶ As would be expected from the economics, smaller and lower-wage employers are much less likely to contribute. Thus in 1994 barely a quarter of workers aged 18-64 in firms with fewer than ten employees were insured through that employment. In contrast, more than two thirds of those workers in firms of more than 500 had health insurance through their jobs.

In each of these cases some employees chose to be insured through another family member's coverage, so the figures understate the proportion of employees who are offered insurance. Some employees also bought individual policies for themselves or their families. Yet even including all possible sources of coverage, in 1994, the proportion of workers aged 18-64 without health insurance was a third in private firms with fewer than ten employees, 24 percent in firms with ten to 99 employees, 15 percent in firms with 100 to 499 employees, and 12 percent in larger firms. Similarly, thirty percent of workers aged 18-64 with total earnings under \$10,000 were uninsured, but only four percent of workers with incomes of \$50,000 or more. As one analysis summarizes, "Low income workers are generally employed in industries less likely to offer health insurance, may have a weaker (or temporary) attachment to the work force, and have less disposable income to allocate to the purchase of health insurance."⁶⁷

- 6) American employers also have much more freedom to try to control costs with provisions that limit benefits. Many plans have caps on total benefits or on some categories of benefits. Some insurance companies try to sell policies that are cheaper because of exclusions for employees with preexisting conditions or even policies that exclude specific employees.⁶⁸ Many policies have caps on total expenses or on expenses in specific categories.⁶⁹ Most plans try to limit expenses with costsharing requirements or by mandating participation in managed care arrangements.

Whether managed care in fact represents a benefit limit is a matter of opinion. The care from a good managed care plan may be of very high quality. However, limits on which doctors one can use tend to be viewed by beneficiaries as a meaningful restriction.⁷⁰ Theorists of managed competition have seen choice among health care plans as a substitute for choice of doctors. Some employers, especially the federal and some state governments, in fact offer such a wide choice among plans. The trend among private employers, however, is to restrict choice. In general, choice makes plans subject to adverse selection and thereby increases costs. If employers can deliver a larger number of covered lives, moreover, they are in a better position to bargain for lower prices from any given insurer. Therefore, an estimated three quarters of employers offer only one plan, and nearly half of workers are offered only one plan.⁷¹

- 7) The last difference is the most elementary: employer-based coverage in the United States is shrinking, because employer participation is voluntary. In 1989, 92 percent of full-time employees in medium and large firms participated in an employer-sponsored medical plan; by 1993, that figure had fallen to 82 percent. Some of this may be due to employees personally declining coverage (e.g. because a spouse had alternative coverage) — but some is clearly a decline in employers

offering coverage.⁷² Coverage for part-time workers also is declining sharply.⁷³ As behavior has changed, so has the informal norm that employers should take care of their employees in this way, as growing numbers of employers believe that even if they do contribute they should contribute a smaller portion of insurance costs. Employers especially believe they should contribute less for employees' spouses and children.⁷⁴

To summarize, Americans pay for health care in roughly equal proportions from employer payments, government general revenues, and individually-paid premiums and out-of-pocket expenses. At least fifteen percent of Americans do not have health insurance, so must rely on a mix of personal payments, publicly paid direct services, and what amounts to charity from providers. The public programs are less adequate for their beneficiaries than the national insurance schemes in other advanced industrial nations: Medicare because its benefits are less, and Medicaid because it accesses a limited supply of providers. Some private insurance coverage is very good and some less so. Even people with good insurance, however, cannot be as secure as citizens of other countries about keeping it.

The extent of insurance coverage, however, is only part of access to health care. Insurance is only useful if there is something it can buy.

1.3.- Supply of Services in the United States and Canada

Although financing arrangements diverged as Canada created its national health insurance system, until that point the Canadian and American health care systems had evolved in very similar ways. Medical education in Canada and the US, for instance, is interchangeable: hospitals in both countries will accept each other's graduates for residencies. Canadian hospitals were accredited by the US accrediting organization until well after World War II.⁷⁵

A physician or hospital bed or nurse therefore means roughly the same thing in the United States as in Canada. How they compare to the same categories in other countries may not be so clear. A hospital bed in many countries is more likely to be as part of a large ward, rather than in a semiprivate room; medical education is not the same around the globe.

In both Canada and the United States the number of acute care hospital beds per person have been slowly falling. Canada has had about half a bed more per thousand persons: thus it had about 4.14 per thousand in the 1989-90 fiscal year, while the United States had 3.6 per thousand in calendar 1990.⁷⁶ The United States has slightly more of a rising number of physicians. Thus by OECD classifications Canada had 2.2 and the US 2.3 physicians per person in 1990.⁷⁷

Relative to Latin American nations these are a lot of physicians and hospital beds. But there are countries with comparable or even greater numbers of physicians, such as Argentina and Uruguay. The huge difference between the US and Canada and poorer nations is in nursing staff. In 1989, by the OECD's definitions, the United States had 6.5 "qualified nurses" per 1,000 citizens, and Canada had 12.7. This means the US had nearly three nurses per physician, and Canada many more.⁷⁸ It is likely that the difference between the United States and Canada is less than it seems, because persons doing specialized medical work might still be called "nurses" rather than some particular kind of technician in Canada. Some analysts and advocates claim that nurse supply in the United

States is less than it seems because many nurses are performing administrative or research or educational work rather than patient care.⁷⁹ Whatever the caveats, however, there is a very much larger supply of nonphysician professional medical personnel in the US and Canada than in any Latin American nation.

Health policy analysts commonly argue that the supply of primary care physicians is more important than the supply of specialists — an opinion that may not be shared by the average patient, and is a lot more plausible when one has yet to be diagnosed with any particular condition. Nevertheless, by this standard Canada might be "better" than the United States. This can only be stated as a probability because of difficulty defining who is a "primary care" physician.⁸⁰ But it seems fair to say that roughly half of Canada's physicians are primary care providers, compared to between a third and forty percent of doctors in the United States.⁸¹ Canadian General Practitioners therefore are likely to provide a wider range of services than their US equivalents. They are particularly more likely to deliver babies: at one Canadian hospital that I visited, obstetricians assisted at only about 30 percent of births. The disadvantage of such a division of labor is, there are situations where specialists on average provide better care.

With comparable numbers of doctors and more beds, Canada might seem to have more capacity to deliver health care than the United States. But the United States clearly has a greater supply per capita of high-technology equipment. There are difficulties with any overall measure of such things, but as one example, one study found five times as many Magnetic Resonance Imagers and ten times as many lithotripters in California as in Ontario.⁸² Aside from large pieces of equipment, there also can be differences in factors such as operating theatres or the supply of nurses with particular specialized training (such as cardiac surgery).⁸³ Waiting lists for elective surgery in particular are therefore much more of an issue in Canada than the United States. American opponents of national health insurance cite these delays as evidence for the superiority of American arrangements.

It would be very difficult, however, to make an argument that American health care is noticeably better than Canadian.

1.4.- Quality of Services in the United States and Canada

The difficulties in measuring quality of health services are immense. In *Competing Solutions* I reviewed the available evidence in order to compare health care in the United States to care in Canada as of 1991. I concluded that at best one might argue that those Americans who have insurance also have slightly better services. The fact that the United States has so many uninsured persons, however, means that its system as a whole cannot be considered superior.

There is little reason to believe the balance has changed. Both systems have been experiencing constraints that cause worries about quality — in Canada from budget cuts and in the United States from managed care. Both systems have also been adopting new medical advances that may improve treatments. In both systems the "guidelines" movement has generated more advice, lots of attention, but not obviously positive results. The difference between Canada and the United States in extent of insurance coverage has only widened.

To summarize the argument in *Competing Solutions*, Canada and many other countries have better infant mortality and life expectancy data than the United States. Health outcomes are a product of health risks as well as medical treatment, and some

of the American disadvantage may be due to the former. But the available data on such risks does not suggest that they explain all of the American shortfall in health outcomes. Data on life expectancy at different ages instead suggests a more measured analysis. The gap between the United States and other countries as to life expectancy narrows with age. And that gap narrows most for and in the population over age 65. Since most of the social pathologies can be expected to have more effect at younger ages, the first point fits suspicions that social pathologies explain much of the health care outcomes gap. But the particular improvement over age 65 suggests that the availability of health care also matters: it is the elderly, unlike other Americans, who are guaranteed medical services.

US advantages over Canada in access to some services (such as imaging and elective surgery) seem to be counterbalanced by two factors. First, American supply advantages may be so excessive that some of the extra service does not help patients. Many more cardiac surgery units means both more surgeries of dubious use, and more surgical teams that perform fewer surgeries than seems necessary to guarantee the highest standard of practice. Second, Canadian advantages in other ways, such as more physician visits and more frequent hospitalization, balance the Canadian disadvantages. Most evidently, few Canadians will do without treatment because they could not afford it. Also, Americans who get tests more quickly from a physician may have taken more time getting to the doctor. In some cases the substitution effects are direct. Canada has a longer average length of stay for hospital patients. It also has less equipment in the hospitals. In part, patients stay longer while waiting for tests.⁸⁴

For purposes of political argument in the United States, the bottom line is that "national health insurance" does not require lower quality of care. For purposes of this study, the main points should be that (a) whatever your system, lots of money buys more than little money; (b) paying for a lot of care privately is not necessary to improve quality; and (c) paying immensely more money than anyone else does not necessarily improve quality. The reasons why much higher spending in the United States than anywhere else does not much improve quality of care will be discussed in chapter two.

Questions of equality in health care basically involve whether identifiable groups of people receive worse services and are less healthy than other groups. Health services can only overcome a portion of any underlying difference in susceptibility to medical problems, because medicine is only partially effective and because it does not eliminate the effects of disease pre-cure. Arguments that the "medical model" is somehow not as important as other factors miss the point: the purpose of medicine is to relieve individual pain and fear once a person encounters some illness. The consequence of medical inequality is that poor people or certain racial and ethnic groups suffer more when sick.

In Canada, all citizens and legal residents have health insurance. That cannot eliminate inequality in health status. Nor does it even fully eliminate inequality in health services. Rural areas are likely to have worse access to physician and hospital services; an accident victim will be further from a trauma center.

But basic statistics before the current squeeze in Canada did not show many differences between rural and urban areas. More rural provinces if anything have had more hospital beds per person, for two reasons: a shrinking or slow-growing population means old capacity is more than adequate, and the role of hospitals in providing jobs to stagnating communities makes closing those facilities quite difficult. In 1989-90 the largest and most urbanized provinces — British Columbia, Ontario, and Quebec — had below four acute care hospital beds per 1,000 population; Prince

Edward Island, New Brunswick, Nova Scotia and Saskatchewan all had more than five.⁸⁵ The difference will be more subtle: a rural "hospital" in fact will have no or a relatively inexperienced surgeon, so the quality of care will not be as good. Inadequacy of services was one justification for closing 52 rural hospitals in Saskatchewan.

A shrinking population may be more likely to be more elderly and to thus have more needs and more time on its hands to go to the doctor. That may explain why the number of surgical visits per 1,000 population and utilization of physician services in Canada do not seem particularly related to provincial urbanization.⁸⁶ People in rural areas naturally will have to travel further for services, and quite a long way for tertiary care services. But Canadian provinces have air ambulance programs to address those needs. The standard of care for the rural population may not be as high as in urban areas, and will always be a political issue, but has still been fairly high.

Inequalities in health status remain because of the effects of income, education, and racial factors. Racial factors will include genetics, lifestyle, and effects of social inequalities. Income will affect access to shelter and nutrition. Education influences income but also should be related to one's ability to take good care of oneself.

There are clear relationships in Canada between education and income, on the one hand, and at least self-rated health status, on the other. Thus less than twenty percent of people with only elementary school education rated their health status as "excellent" in a 1990 survey, while over thirty percent of university graduates gave themselves that rating. Almost twenty percent of the elementary school group rated their health "fair" or "poor", compared to about six percent of the university graduates. Similarly, about a third of the "very poor" rated their health "fair" or "poor", compared to less than ten percent of the upper middle income and the rich.⁸⁷

Because all Canadians have the same basic insurance, there is little scope for inequalities in access due to differences in coverage. Nevertheless, no system is entirely equal. Canada is no exception to Marilyn M. Rosenthal's conclusion that, "the well-educated and assertive patient is best able to make a particular system work at some level of satisfaction."⁸⁸ Moreover, persons with more money may purchase amenities such as private rooms. And some may even choose to visit the United States for elective surgery. All these inequalities, however, constitute "safety valves" through which the better off escape and obtain better care than a very decent societal norm.

The pattern of inequalities in health outcomes in the United States is in many ways similar to that in Canada. In both countries the health of native populations is abysmal compared to the norm. Services in the areas in which they live are likely to be inferior, but they are also poorer, have genetic weaknesses (especially involving alcohol), and basically are more likely to lead miserable, unhealthy lives.⁸⁹

As in Canada, rural/urban differences in the United States are not large. In 1993 14.3 percent of persons within a Metropolitan Statistical Area and 15.7 percent outside one (so more rural) had some "limitation of activity." 11.1 percent of the more rural group and 9.4 percent of the less rural reported "fair or poor" health status. Rates of vaccination in more rural areas were slightly lower than for suburbs but higher than for central cities.⁹⁰

The significant health inequalities in the United States involve poverty/education and race. Many poor people do have access to medical services in the United States, through programs such as Medicaid or charity or other government programs. But there is about a ten percent difference in vaccination rates: for instance, 80.6 percent of poor children 19-35 months of age in 1993 were inoculated for DTP, compared to 90.8 percent of children at or above the poverty line. Almost three times as many poor people

as upper-income people reported some "limitation of activity." Similarly, 21.4 percent of persons with family incomes under \$14,000 reported fair or poor health status, compared to only 3.9 percent of persons with family incomes of \$50,000 or more. In all these cases we should remember that poor health is not simply caused by poverty; the relationship may instead be that poor health creates poverty. But that remains a reason to improve medical services to the poor.⁹¹

Poor people in the United States actually have more physician visits than people with more money. But that is because the poor are more likely to be sick. Controlling for self-reported health status, the poor are significantly less likely to see physicians. But these differences are within fairly high numbers. Poor females who report "fair or poor" health averaged an estimated 15.1 physician contacts in 1993, compared to 23.0 for the non-poor. Moreover, levels of insurance do not explain all the difference. Among the elderly population, in which virtually everyone is covered by Medicare, poor women had only slightly fewer visits than non-poor women. But the difference among men was similar to that in the population as a whole.⁹²

Racial differences in the United States of course are a more significant issue than in Canada because of America's different history and demography. And they are confounded with differences in education and income. Blacks are modestly more likely than whites to report some limitation of activity (17.8% vs. 14.4% in 1993) and distinctly more likely to report inability to carry on some major activity (7.2% vs. 4.0%). Blacks are almost twice as likely to assess themselves as being in "fair" or "poor" health. These differences are not as large, however, as differences based on income.⁹³ It is impossible to determine, of course, to what extent race in the United States causes lower income.

What is obvious, however, is that lower income reduces the probability of being insured. In 1994 over a third of Americans with family incomes below \$20,000 were uninsured, compared to less than twelve percent of Americans with higher incomes — in spite of the existence of Medicaid.⁹⁴ The rate of uninsurance was substantially higher among blacks (21.3%) than whites (13.5%), and much higher among Hispanics (35.5%). But the difference between whites and blacks was mostly due to blacks being poorer (in fact, among families with incomes below twice the poverty level, blacks were more likely than whites to be insured). The low levels of uninsurance among Hispanics may be related to immigration questions that affect relationships with both employers and the government.

Some people with no or insufficient medical insurance will find ways to get care. They may pay out of pocket, or have some charity care. And, as proof that "the market" responds to any need (or opportunity), some, but only those who seem certain to die soon, sell their life insurance policies at a discount in order to get the money for the care that would limit their misery.⁹⁵ But this latter, rather ghoulis development only highlights the costs of doing without good health insurance: people who have much hope of living would make very bad customers.

There can be no doubt that better health insurance provides better protection. Lack of insurance clearly leads to lower quality or fewer medical services, controlling for health status. A careful study of American hospitals showed that the uninsured were sicker when admitted, received less extensive care, and more likely to die as a result of a given condition.⁹⁶ Controlling for other factors, uninsured children were nearly twice as likely as insured children to go without ambulatory care for four conditions "when it seems reasonably indicated and are therefore at risk for substantial avoidable morbidity."⁹⁷ A more recent analysis of the available data showed that the uninsured have a 25 percent higher risk of mortality, controlling for other variables, as

well as being less likely to receive services.⁹⁸ A 1996 survey found that 45 percent of the uninsured, compared to only 11 percent of the insured respondents, "said they needed health care and could not get it at some time in the year before the survey." And, "only 37 percent of the uninsured who reported problems in paying medical bills said that they had received medical care for free or for a reduced charge in the previous year," in spite of arguments, made frequently in the United States, that people without insurance receive sufficient charity care instead.⁹⁹

Even the data that is most frequently used in the United States to support arguments that levels of insurance are not so important — the RAND Health Insurance Experiment that measured the effects of large deductibles — in fact found significant differences in death rates among the poor between those with "free" care and those who faced greater price constraints due to high deductibles — largely due to higher death rates for people with high deductibles and high blood pressure. Moreover, among the lowest 40 percent of the distribution for socioeconomic status and family income, the higher cost-sharing population had significantly higher incidence of five serious symptoms.¹⁰⁰

Among the insured population, there is no data that allows strong generalizations about better or worse services or outcomes compared to Canada. Clearly, given the variety of coverages and forms of managed care, there are large differences among insured Americans as to choice of provider and some elements of access to care. Some of the most significant differences from a patient's perspective might involve the sheer complexity of the systems they have to negotiate to find doctors or pay them. The Medicare population has greater effective choice than the norm, and the Medicaid population less. These differences must be greater in the United States than in Canada. The Canadian system is more egalitarian. But whether these differences in the United States create major differences in outcomes for the insured is very questionable. They may be associated with differences in satisfaction with the system as a whole (which has been lower in the US than Canada), but not necessarily lead to dissatisfaction with one's personal medical care (which has been much more comparable between the two countries)¹⁰¹

To summarize, this review of patterns of health care and outcome inequalities in the United States and Canada suggests five points:

- 1) In assessing health care inequalities, it is important to remember that a substantial majority of Americans have health insurance most of the time, and that even uninsured people receive some care. Moreover, health care can only make up for some of the differences in health created by other factors. Therefore one should not expect the raw differences in outcomes or service levels explainable by differences in medical care to be large, and they are not.
- 2) Above some given level of service, inequalities may not matter much. Neither the US nor Canada provides equal care to rural and urban areas. But they so far have spent enough money to provide pretty good care in the former.
- 3) Universal health insurance does not eliminate inequalities in either health outcomes or even services. One should not expect huge differences in the pattern of inequalities between the US and Canada. After all, a substantial majority of Americans are insured most of the time, and the sickest portions of the population (the elderly and disabled) are insured permanently, through Medicare.

- 4) Nevertheless, differences in both health services and outcomes are caused by differences in access to health insurance. These in turn are related to the same factors, income and education and perhaps discrimination, that otherwise cause differences in health outcomes. Canada's government, through universal health insurance, has done more to equalize health care and outcome than has the United States government, through its hodgepodge of government programs and tax breaks.
- 5) Between the insurance arrangements of the two countries, the biggest difference is that Canadian inequalities consist of modest safety valves by which some better-off citizens obtain more than a very decent standard. America's major inequalities involve holes in a "social safety net," through which some Americans fall into a situation with less than decent care.

1.5.- Conclusion

In this chapter we have reviewed basic insurance arrangements and some information about supply of medical services for the United States and Canada.

In Canada, health insurance is an entitlement for all citizens, provided by provincial governments according to basic rules and with some financial support from the federal government. The basic insurance package is generous inasmuch as there is almost no costsharing. It is not, however, as extensive as in countries like Germany. Some services are part of separate government reimbursement schemes, more targeted and less universal, as with pharmaceutical benefits. Others are covered, for most persons, through employment-based private insurance.

In the United States, health insurance arrangements are a hodgepodge of categorical public programs (the elderly, the poor, veterans) and contractual private arrangements. As a result at least fifteen percent of Americans have no health insurance. Most people in the main public plan, Medicare, have supplementary private coverage. The benefits of private plans vary greatly, as do the ways in which they deliver benefits.

Both countries have far greater supplies of medical plant and personnel than in any poor nation. Their supplies of physicians are at the high end of international tables: not as high as some (like Germany and France) but well above some other OECD nations (like Japan and the United Kingdom). Each is fairly well-along in the rich nations' rush to eliminate hospital beds; the United States being slightly further along. Canada provides more of some services per capita, such as physician consultations and hospitalizations. The United States provides higher rates of elective surgeries. On balance, it would be hard to say that the quality of care in one country is, on average, higher than the other.

But the variation is greater in the United States. Canada's universal health insurance cannot eliminate internal inequality in health outcomes. People with worse lives have worse health, everywhere. But clearly inequality of outcomes is exacerbated, in the United States, by differences in health insurance. The outcomes data suggests that maximizing the spread of insurance is more efficient, as well as more equitable, than intensifying the services available to some citizens while allowing others to have far inferior services.

Table 1
Total Health Expenditure in Canada, by Sector of Finance¹⁰²

Public Sector:	71.8%
Provincial Spending	66.3%
Federal Transfers	21.9%
Provincial Funds	44.4%
Federal Direct	3.6%
Municipal	1.2%
Workmen's Compensation	0.8%
Private Sector:	28.2%

Table 2
Health Services Expenditure in US, by Source, 1991

Employer Payments:	33.6%
(Private)	28.2%
(Government)	5.4%
Public Payments from General Revenues:	29.5%
Household Payments:	33.9%
(Insurance)	14.1%
(Out-of-Pocket)	19.8%
Other:	3.0%

Source: National Center for Health Statistics, *Health, United States, 1994* (Hyattsville, MD: Public Health Service, 1995) table 121 with author's calculations.

Notes: "Government Payments" within the employer category refers to payments into insurance schemes for government employees. "Employer Payments" also includes the employer contributions to the Medicare payroll taxes. "Household Payments" for insurance includes employee contributions to Medicare and employer-sponsored plans, as well as other individual purchases of insurance. "Other" mainly consists of charitable contributions.

Endnotes for Chapter 1

⁸ I say it does not because such mandates have been made by organizations other than governments, such as guilds, and long preceded development of the modern state. But some might argue that effects and parallels are more important than origins.

⁹ For comparisons to rich OECD countries see Joseph White, *Competing Solutions: American Health Care Proposals and International Experience* (Washington: The Brookings Institution, 1995); for comparisons to Latin America I rely on the accounts in PAHO, *Health Conditions in the Americas* and in Ramesh Govindaraj, Christopher J. L. Murray, and Gnanaraj Chellaraj, "Health Expenditures in Latin America," World Bank Technical Paper No. 274 (1995).

¹⁰ Canada transfers money in two ways, "tax points" — a share of the income tax — and cash. The federal government has pledged to hold its total health, education and welfare transfer at the same figure from 1997 to 2000, and its guaranteed cash figure for these transfers, at \$11 billion, is \$7.2 billion less than the 1995-96 figure. So evidently the federal share of health finance will continue to fall significantly. See *Maclean's*, December 2, 1996, pp. 45-46.

¹¹ Health Canada, *National Health Expenditures in Canada 1975-1994: Full Report* (Policy and Consultation Branch, Health Canada, January 1996). Table 25B shows per capita transfers during 1994 to the ten provinces ranging from a low of \$535.29 in Manitoba to a high of \$553.20 in Newfoundland. But when these figures are compared to the public sector health expenditures per capita from Table 21B, the proportion of the provincial bill paid by the federal government ranged from a low of 27.8% in British Columbia to a high of 35.2% in Prince Edward Island. Note that these proportions are based on all public sector spending in a province, rather than just provincial health insurance, so slightly understate the federal share of provincial health insurance.

¹² For the 1993-94 trend see *ibid*, Figure 20 (p.51). For one source on the worries, see Canadian College of Health Service Executives: "Special Report: External Environmental Analysis and Health Reform Update" (Ottawa: Summer, 1995) p. 13.

¹³ The current definition of "accessibility," however, was only legislated in 1984.

¹⁴ For a summary of benefits see National Forum on Health, "The Public and Private Financing of Canada's Health System," (Sept 1995) pp. 6-7.

¹⁵ National Health Forum, "The Public and Private Financing of Canada's Health System," (Sept 1995) p. 16.

¹⁶ *ibid*, pp. 16-17, and *Maclean's* December 2, 1996, p. 60.

¹⁷ National Health Forum, "Public and Private Financing," p. 6.

¹⁸ Author's calculations of spending trends from *ibid*, p. 20. Most obviously, pharmaceutical prices have not been subject to the same controls.

¹⁹ "National Health Expenditures in Canada: Highlights" p. 18.

²⁰ Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1995 Current Population Survey" *EBRI Issue Brief Number 170* (February, 1996) p. 4; U.S. Congress, House Committee on Ways and Means, *Overview of Entitlement Programs—1993 Green Book* (Committee Print 103-18), pp. 239-41.

²¹ Employee Benefit Research Institute, "Health Insurance Portability: Access and Affordability" *EBRI Issue Brief Number 173* (May, 1996) p. 1.

²² Robert Pear, "Health Costs Pose Problems For Millions, A Study Finds," *New York Times* 10/23/96, p. A18. See also Ron Winslow, "Study of Access to Medical Care Finds Outlook Remains Grim for Uninsured," *Wall Street Journal* 10/23/96, p. B9.

²³ This 19.5 million figure is EBRI's estimate; I assume that you cannot simply subtract the 1994 uninsured figure from the March, 1995 figure because of adjustments such as having uninsured newborns in 1995.

²⁴ I can illustrate these points with a personal anecdote. At one point I changed my major source of employment. Under the "Cobra" provisions of federal law (named after the Consolidated Omnibus Budget Reconciliation Act of 1986) I could continue my health insurance with the previous employer by paying the premiums that the employer had previously paid. And I had sixty days in which to make that payment. In fact, I chose instead to participate in insurance through my wife's employer. But we could not put me in her plan until the beginning of the pay period a week after my old employer stopped paying. So: was I covered for the week in between? If I had had major expenses, I suppose I would have asserted that I was planning to pay my Cobra premiums and billed my old insurer. I do not know if that would have worked.

²⁵ EBRI, "Health Insurance Portability," p. 4.

²⁶ EBRI, "Sources of Health Insurance," p. 1.

²⁷ In part this is an "apples and oranges" comparison. Benefits for private managed care plans will be more extensive but internally rationed; Medicare benefits are less extensive but not rationed. But throughout the debates of 1993-94, informal cost estimates by Congressional estimators presumed that the cost of "Medicare for all" would be slightly less than the average per capita cost of existing private plans, while the absence of pharmaceutical coverage means Medicare is clearly below the normal benefits for large employer plans.

²⁸ See the discussion and sources cited in *Competing Solutions*, p. 43.

²⁹ Levitt et al, "Health Care Spending in 1994..." pp. 139-40; *Health, United States, 1994* Table 121 (p. 225).

³⁰ Medicare and Medicaid alone pay nearly 45 percent of hospital charges. See *Health Care Financing Review Statistical Supplement 1995* (Sept. 1995) p. 1; Katharine R. Levit, Helen C. Lazenby, and Lekha Sivarajan, "Health Care Spending in 1994: Slowest in Decades" *Health Affairs* (Summer, 1996, 15:2) pp. 139-42.

³¹ 1995 enrollment figures from *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, p. 3; in 1993 there were about 229,000 End Stage Renal Disease beneficiaries, according to *HCFR Statistical Supplement 1995*, p. 2. The HI premium for 1996 was \$289.00 for most persons and \$188.00 for certain disabled persons; see *1996 Annual Report* p. 76.

³² *HCFR Statistical Supplement 1995*, pp. 4-5; *1996 Annual Report* p. 74.

³³ *HCFR Statistical Supplement 1995*, pp. 2, 4-11, 100.

³⁴ Author's calculations from *1996 Annual Report*, p. 75.

³⁵ *HCFR Statistical Supplement 1995*, pp. 48-49.

³⁶ The payroll tax in 1995 was 86 percent of total revenues to the fund, and more than 94 percent of the revenues excluding paper transfers in the form of "interest" paid by the federal government to itself. Author's calculations from *1996 Annual Report*, p. 32.

³⁷ When created in 1966, Medicare's payroll tax was limited, like the similar tax for social security pensions, to only a portion of wages. Wages above the cap were not subject to tax, just as the wage base for contributions for social solidarity is capped in Germany. However, as part of budget politics, the taxable wage base for Medicare was more than doubled in the deficit reduction legislation of 1990 and then the cap was removed in the legislation for 1993.

³⁸ For good because it directs attention to program cost trends and affordability; for ill because it leads to ridiculous arguments in which parties justify spending cuts or contribution increases in terms of "saving" the HI trust fund even when the savings or contribution increases are part of SMI — as was true of both the Republican Congress's and President Clinton's proposals in 1995.

³⁹ Sources on Medicaid participation are mildly inconsistent. The Kaiser Commission on the Future of Medicaid, based on Urban Institute calculations from HCFA data, report 34.8 million beneficiaries in 1995.

(Chart Pack: "Where is Medicaid Spending Headed?" December 3, 1996, Figure 2.) Levit et al report 35.1 million beneficiaries in 1994: "Health Care Spending in 1994", p. 142, and they should know. But the survey data used in most estimates of national insurance coverage, being an estimate, does not match the figures compiled directly from program data: it reported 31.5 million Medicaid beneficiaries for 1994 (EBRI, "Sources of Health Insurance", p. 5).

⁴⁰ *HCFR Statistical Supplement 1995*, p. 11.

⁴¹ Kaiser Commission, "Where is Medicaid Spending Headed?" figure 1.

⁴² *HCFR Statistical Supplement 1995* pp. 118-20.

⁴³ For example, in one study sixty percent of 330 private practices contacted agreed to see a patient with private insurance within two days, but only 26 percent agreed to see a patient covered by Medicaid so quickly. The Medicaid Access Study Group, "Access of Medicaid Recipients to Outpatient Care," *New England Journal of Medicine* 330:20 (May 19, 1994) pp. 1426-30.

⁴⁴ *Health Care Financing & Organization News & Progress* March, 1995, p. 4.

⁴⁵ For a very slightly out-of-date review of Medicaid's problems see Kaiser Commission on the Future of Medicaid, *Medicaid at the Crossroads* (Menlo Park, CA., November 1992).

⁴⁶ Kaiser Commission, "Where is Medicaid Spending Headed?" Figure 3. Note that figures on the proportion of Medicaid spending that go to particular classes of beneficiaries are made confusing by the fact that a portion goes directly to hospitals as "Disproportionate Share Hospital Payments," as explained below. DSH payments were 12.5 percent of Medicaid's total in 1995. So the low-income family spending was 28.7% of total Medicaid, but 31.6% of the amount that could be allocated by category of individual. See *ibid*, figure 2.

⁴⁷ The federal government pays a larger share of a few costs, such as family planning and services for Indian tribes. *HCFR Statistical Supplement 1995*, p. 123.

⁴⁸ The quote is from Dan Morgan, "Medicaid Loopholes Closing for Strapped States," *Washington Post* February 7, 1993, p. A23. See also Dan Morgan, "Medicaid Windfall Cut N.H. Deficit," February 28, 1993, p. A1; Dan Morgan, "Medicaid Funds Release Adds to Deficit," February 7, 1993, p. A1.

⁴⁹ An estimated 3/8 of the 1991-92 increase in Medicaid spending was due to such creative financing by states, used to raise DSH payments; see The Kaiser Commission on the Future of Medicaid, "The Medicaid Cost Explosion: Causes and Consequences" (Henry J. Kaiser Family Foundation, 1993) pp. 23-25.

⁵⁰ Historically, support for aid to veterans far preceeded support for health care for other citizens. Politically, veterans are a very powerful interest group. Practically, veterans now and in the past have had some special needs, such as rehabilitation from war wounds, which justify some special facilities.

⁵¹ In 1995 health research and training outlays were \$11.6 billion; health care services aside from Medicaid and federal employees were \$9.2 billion; consumer and occupational health and safety \$1.9 billion; and this does not include federal grants for clean water, or employee and military programs, or nutrition programs. See *Budget of the United States Government*, "Analytical Perspectives," Table 15-12.

⁵² Bureau of National Affairs, *Health Care Trends Report* (May 13, 1996) p. 815. In 1991 public hospitals received 46 percent of their revenues from Medicaid, as opposed to 12-13 percent for all U.S. hospitals. Over 30 percent of discharges were "self-pay" patients, meaning uninsured, which again is three times the national average. Debra J. Lipson and Naomi Naierman, "Effects of Health System Changes on Safety-Net Providers," *Health Affairs* (15:2) p. 34.

⁵³ See Larry S. Gage et al, "America's Essential Providers: The Foundation of Our Nation's Health System" available from the National Association of Public Hospitals, pp. 15-26, for useful data and descriptions from an advocacy perspective.

⁵⁴ John K. Iglehart, "Averting Disaster: A Conversation With the Los Angeles County 'Health Czar'" *Health Affairs* (15:1) Spring, 1996 pp. 87-91.

⁵⁵ Lipson and Naierman, "Effects... On Safety-Net Providers," p. 40.

⁵⁶ EBRI, "Sources of Health Insurance," p. 6.

⁵⁷ Milt Freudenheim, "Health Insurers, to Reduce Losses, Blacklist Dozens of Occupations," *New York Times*, Feb 5, 1990, p. A1; U.S. General Accounting Office, *Private Insurance: Problems Caused by a Segmented Market* GAO-HRD-91-114 (July, 1991).

⁵⁸ The history of New York's Empire Blue Cross and Blue Shield is replete with conflicts over such subsidy schemes. Generally the community-rated plan once dominated the market and is still large enough to have a substantial market share, so with help from the state it can try to extract lower prices from hospitals and other providers, in order to compensate for its sicker patients. But as other payers grow and can extract their own discounts, this subsidy process for the community-rated payer breaks down.

⁵⁹ White, *Competing Solutions* p. 41.

⁶⁰ Nor should they, though it is likely that a majority of employers' health care contributions do replace wages; see White, *Competing Solutions*, pp. 274-76.

⁶¹ EBRI, "Sources of Health Insurance...1995" p. 20. Note that these proportions had declined from 74 percent and 54 percent in 1980.

⁶² For descriptions of those other systems see White, *Competing Solutions*.

⁶³ In 1994 payments for health care by private industry were estimated at 6.7 percent of total compensation. This may seem similar to the proportion of wages paid by employers in Germany. But wages are not compensation; the percent of wages figure in the United States would be 9.4 percent. Furthermore, these figures fail to distinguish employers that contribute to insurance from those that do not. The former clearly pay more than the average, as can be seen from data comparing groups that are relatively more or less likely to contribute. Thus unionized employers pay 9.8 percent of compensation and 15.4 percent of wages while nonunion employers pay 5.9 percent of compensation and 8.0 percent of wages; employers with 500 or more employees pay 7.9 percent of compensation and 11.7 percent of wages while employers with fewer than 100 employees pay 5.7 percent of compensation and 7.8 percent of wages. Data and calculations from National Center for Health Statistics, *Health United States, 1994* Table 122.

⁶⁴ How thoroughly the Employee Retirement Income Security Act (ERISA) prevents states from taking action having any effect on self-insured plans is currently being reinterpreted by the courts. But precedent is strong that ERISA prevents states from regulating self-insured plans in a great many ways that are perfectly legal for third-party insurance. See, e.g., Patricia A. Butler, "Roadblock to Reform: ERISA Implications for State Health Care Initiatives," (Washington: National Governors' Association Center for Policy Research, 1994). For pro-ERISA advocacy see G. Lawrence Atkins and Kristin Bass, "ERISA Preemption: The Key to Market Innovation in Health Care," (Washington: Corporate Health Care Coalition, 1995).

⁶⁵ For more on this issue see White, *Competing Solutions*, pp. 39-46; Debra J. Lipson and Jeanne M. De Sa, "Impact of Purchasing Strategies on Local Health Care Systems," *Health Affairs* (15:2) pp. 64-65; and the sources each cites.

⁶⁶ They do have to pay towards Medicare, but 1.45 percent of payroll is a relatively small amount.

⁶⁷ EBRI, "Sources of Health Insurance" quote p. 18, data pp. 8, 18. For a table showing the interaction of firm size and wage level effects in 1992 see White, *Competing Solutions*, p. 41. Note that distinctions within sickness fund systems among employers of various sizes are common. The difference is, countries such as Germany and Japan created compulsory, somewhat subsidized insurance pools for smaller and lower-wage groups.

⁶⁸ In one famous example, the *Wall Street Journal* reported that the Republican National Committee was told its insurance would cost a lot more unless it excluded its then-chairman, the late Lee Atwater, who had a brain tumor. Michel McQueen, "Ills of the Nation's Health-Care System Are Pulling GOP Into Search for New Cures," (June 24, 1991) p. A12. Another example is Golden Rule Insurance Company, the main promoter of "catastrophic" insurance plans, refusing to cover a diabetic. See Marilyn Werber Serafini, "Going for the Gold," *National Journal*, April 1, 1995, pp. 805, 808.

⁶⁹ Employee Benefit Research Institute, "Features of Employer-Sponsored Health Plans," *Issue Brief No. 128* (August, 1992); Ellen E. Schultz, "Beware of Coverage Gaps in Today's Health Plans," *Wall Street Journal*, Sept 29, 1993, C1.

⁷⁰ As one example see "Employees Rate Choice of Doctors More Importantly Than HMO Quality," *BNA's Health Care Policy Report* (April 15, 1996) p. 677.

⁷¹ On the consequences of plan choice see Stanley Jones, "Multiple Choice Health Insurance: The Lessons and Challenge to Private Insurers," *Inquiry* 27 (Summer, 1990) pp. 161-66; on the trend see Lipson and De Sa, "Impact of Purchasing Strategies," pp. 63-64.

⁷² Office of the Chief Economist, U.S. Department of Labor, "A Look at Employers' Costs of Providing Health Benefits," Technical Appendix, p. 7, (July 31, 1996); David Wessel, "Firms Cut Health Costs, Cover Fewer Workers," *Wall Street Journal* November 11, 1996, p. A1.

⁷³ Robert Langreth, "Employers' Health Costs Are Stabilizing," *Wall Street Journal* October 7, 1996, pp. A2, A16.

⁷⁴ Spencer Rich and Judith Havemann, "As the Young Lose Faith in Medicare, Corporations Retreat on Health Coverage," *Washington Post*, October 9, 1996, A21.

⁷⁵ For discussion of similarities see Theodore R. Marmor, "Commentary on 'Canadian Health Insurance: Lessons for the United States,'" *International Journal of Health Services* 23:1 (1993); Gordon H. Hatcher, Peter R. Hatcher, and Eleanor C. Hatcher, "Canada," in Marshall W. Raffel, ed., *Comparative Health Systems* (Pennsylvania State University Press, 1984). A nice recent example of the interchangeability of training is the advice from the *Wall Street Journal* in a guide to picking a physician that, "it is safest if your prospect has graduated from a medical school in the U.S. or Canada, which have consistent standards for quality." Robert Langreth, "Picking a Plan," October 24, 1996, p. R4.

⁷⁶ Data sources are not ideal on these matters, partly because of problems of definition. The 1989-90 figure is from Representation and Research Division, British Columbian Health Association, "Figuring Health Care, 1993" Graph 3.4. The 1990 U.S. figure is from OECD Health Data 1993 (computer database). The U.S. figure for "short-stay" hospital beds in 1992, apparently a slightly broader category, was about 3.9 per thousand. See *Health, United States, 1994* Table 108 for raw data. That table shows the trend of declining beds. Canadian trends in this direction can be seen in OECD data and are if anything accelerating; see Canadian College of Health Service Executives, "Special Report," pp. 26-27.

⁷⁷ *OECD Health Data 1993*. For the U.S. trend in raw data see *Health USA 1994* Table 99; that source counts 2.46 active physicians per thousand in the United States in 1993, including Doctors of osteopathy.

⁷⁸ *OECD Health Data 1993*; The figures for "registered nurses" in *Health USA 1994* would suggest that the total had grown to 7.4 per 1,000 in the U.S. by 1992. (Author's calculation) Note that the number of nurses has been growing very quickly, as that source's table 102 shows: from 1,272,900 in 1980 to 1,893,400 in 1992.

⁷⁹ On American nurses see Spencer Rich, "At Hospitals, Cutting Costs or Corners?" *Washington Post* May 27, 1996, p. A6. The Canadian caveat has been expressed to me in interviews.

⁸⁰ In a system like the United Kingdom's that creates a hard boundary between ambulatory care physicians who see the patient first (except in an emergency) and hospital-based "consultants," it is easy to distinguish "primary" from "specialist" care. But the U.S. and Canada do not have such systems, so the difference between primary and other caregivers becomes a matter of much more dubious medical definition. "Primary" care cannot just mean unspecialized care; a pediatrician, for instance, is specialized but also may be the physician of first reference for any child. Nor do advocates of primary care mean it in the dictionary sense, the most important physician to a patient, because a person with a serious chronic condition then would see the appropriate specialist (say, a cardiologist) as her primary physician. Nor is it necessarily a physician with whom a patient has a regular, recurring relationship that includes prevention and testing as well as responses to disease: that definition would include gynecologists, which some people would dispute.

⁸¹ On the United States see the figures for "Primary care generalists" and "Primary care specialists" in *Health USA 1994* table 103. On Canada see John K. Iglehart, "Canada's Health Care System Faces Its Problems," *New England Journal of Medicine* February 22, 1990, pp. 562-68. The OECD database figures leave a lot of questions, but still suggest that Canada has a smaller proportion of specialists than in the United States.

⁸² Donald A. Redelmeier and Victor R. Fuchs, "Hospital Expenditures in the United States and Canada," *New England Journal of Medicine*, March 18, 1993, pp. 775-77.

⁸³ The latter contributed to waiting lists for cardiac surgery in British Columbia; see Steven J. Katz, Henry F. Mizgala, and H. Gilbert Welch, "British Columbia Sends Patients to Seattle for Coronary Artery Surgery: Bypassing the Queue in Canada," *Journal of the American Medical Association*, August 28, 1991, pp. 1108-11.

⁸⁴ *Competing Solutions* chapter 6, especially pp. 133-36, 140-49.

⁸⁵ BCHA, "Figuring Health Care," Graph 3.4.

⁸⁶ *ibid*, graphs 3.09, 3.22.

⁸⁷ *ibid*, graphs 2.15 and 2.16. Similar data is reported for British Columbia, only in terms of the proportions by income rating their health as "Excellent" or "Very Good" for the 1994-95 National Population Health Survey; see "A Report on the Health of British Columbians: Provincial Health Officer's Annual Report," 1995, BC Ministry of Health and Ministry Responsible for Seniors, p. 6.

⁸⁸ Marilynn M. Rosenthal, "Systems, Strategies, and Some Patient Encounters: A Discussion of Twelve Countries" in Marilynn M. Rosenthal and Marcel Frenkel, eds., *Health Care Systems and Their Patients: An International Perspective* (Boulder, CO: Westview Press, 1992) p. 334.

⁸⁹ Thus in British Columbia, life expectancies for the "aboriginal" population is twelve years shorter than for the overall population; "Provincial Health Officer's Annual Report, 1995" p. 7.

⁹⁰ *Health USA, 1994* Tables 62, 63, 55. Vaccination rates for polio were actually higher outside Metropolitan Statistical Areas.

⁹¹ *ibid*, Tables 55, 62, 63. In 1993 26.0 percent for people with family incomes less than \$14,000, and 9.2 percent for people with family incomes of \$50,000 or more, reported some limitation of activity. The difference in rates "unable to carry on major activity" is even larger: 10.7 percent for the former group and only 1.5 percent for the latter. But that statistic is particularly likely to be due to a reverse causation: naturally, people with major disabilities are likely to have low incomes.

⁹² *ibid*, Table 77. The figures for physician visits in 1991-93 by persons with fair or poor health status were:

	Poor	Near Poor	Nonpoor
All Persons:			
Male	12.6	14.7	17.1
Female	15.1	15.9	23.0
Age 65+ :			
Male	14.2	14.4	19.0
Female	18.4	18.1	20.9

⁹³ *Health USA, 1994*, tables 62 and 63. For example, in 1993 8.8 percent of whites and 16.8 percent of blacks reported themselves to be in fair or poor health. But the spread between the poorest and richest groups, as reported above, was greater.

⁹⁴ EBRI, "Sources of Health Insurance," author's calculations from data in Table 5, based on the "insured in 1994" question.

⁹⁵ This business is known as "viatical" services; see Arthur Allen, "As They Lay Dying," *Washington Post Magazine*, Nov. 17, 1996, pp. 13-17, 28-32.

⁹⁶ Jack Hadley, Earl P. Steinberg, and Judith Feder, "Comparison of Uninsured and Privately Insured Hospital Patients," *Journal of the American Medical Association* 265:3 (January 16, 1991) pp. 374-79.

⁹⁷ Jeffrey J. Stoddard, Robert F. St. Peter, and Paul W. Newacheck, "Health Insurance Status and Ambulatory Care for Children" *New England Journal of Medicine* 330:20 (May 19, 1994) pp. 1421-25; quote p. 1421.

⁹⁸ Urban Institute study reported in *BNA's Health Care Policy Report*, May 6, 1996

⁹⁹ Pear, "Health Costs Pose Problems For Millions, A Study Finds"; also see Winslow, "Study of Access to Medical Care Finds Outlook Remains Grim for Uninsured".

¹⁰⁰ The symptoms were chest pain when exercising; bleeding not caused by an accident, injury, nosebleed or menstruation; loss of consciousness or fainting; shortness of breath with light exertion; and weight loss of ten pounds or more without dieting. See Joseph P. Newhouse and the Insurance Experiment Group, *Free*

for All? Lessons from the RAND Health Insurance Experiment (Cambridge: Harvard University Press, 1993) pp. 191, 219. It also should be noted that a study that tracked a total of about 6,000 persons for three to four years, even though massive by social science standards, may miss effects that are rare and take time to develop: like most differences in mortality rates. Over twenty years the results might be different.

¹⁰¹ Robert J. Blendon, Robert Leitman, Ian Morrison, and Karen Donelan, "Satisfaction With Health Systems in Ten Nations," *Health Affairs* 9:2 (Summer, 1990) pp. 185-92.

¹⁰² Source: "National Health Expenditures in Canada: Highlights", pp. 16 and 20.

2.- PAYING AND CONTROLLING PAYMENTS

Throughout the world, government policymakers are puzzling over how to get the most for their nations' health care dollars.

In countries with universal health insurance, finance and economics ministries worry about the programs' burdens on the national deficit (if treasury-financed) or employment (if a sickness-fund system). In countries without universal insurance, governments worry about costs for two reasons. They are normally poor countries to begin with, with policymakers facing many competing needs. And believers in social progress tend to view extension of health insurance or services as desirable.¹⁰³ People who want to expand insurance seek greater efficiency to make expansion affordable.

The United States is unique in that it has all possible reasons to worry about health costs. Its health sector is a major burden on its government's budget, yet has simultaneously been a direct burden on many employers. Therefore cutting programs has been on the agenda. But so has expansion, since so many Americans are uninsured or insecurely insured. This combination of evils is possible only because the United States has managed to combine the world's most expensive health care system, by far, with only partial coverage.

It is ironic, then, that so much international attention is devoted to American theories of cost control, such as Alain Enthoven's "managed competition." As Enthoven himself has admitted, judging from experience alone, the United States is not where one would look for advice on health care cost control. American theories do, however, have some distinct advantages for foreigners who are searching for options. First, they have not been tried yet in those countries, so they are alternatives to the status quo. State managers who have been under attack for the standard international cost control measures can be expected to wish to avoid intensifying those measures, with the predictable backlash, so to be interested in measures with less predictable backlash. Second, the most up-to-date American theories, almost by definition, are those that have not really been tried in the United States either, so their failure has not been demonstrated. Finally, a critical mass of economists and other analysts devote their lives to showing "waste" in health care systems that cannot obviously be squeezed out by the traditional methods. Naturally, policy-makers are attracted by the idea that some other methods could come close to perfect efficiency.¹⁰⁴

Canada itself only looks like a good example compared to the United States. Expressed as a share of GDP, Canada has the second most expensive health care system in the OECD (though it is less than three-quarters as expensive as America's).¹⁰⁵ Moreover, through the 1980s and early 1990s, Canada trailed only a few OECD nations in its rate of per capita growth in health care spending.¹⁰⁶ Canada and the United States easily top the health care spending charts among the G-7 major industrial powers.

One message from this paper, therefore, should be that policymakers who are looking for ways to make their health care systems more efficient really do need to look beyond Canada and the United States. Nevertheless, the differences between Canada and the United States may be more instructive than either country's experience alone. Comparing Canada and the United States is a natural experiment that controls for many non-policy factors that are hard to measure and might influence spending outcomes.¹⁰⁷

Not only did Canada and the United States have very similar evolutions of their health care systems until Canada implemented national health insurance in the 1960s, but their spending paths were parallel before, upon full implementation of Canada's national health insurance in 1971, diverging significantly. In 1971 US health care spending was 7.5% of GDP and Canadian was 7.4%. By 1982 the US was at 10.3% and Canada at 8.4%. By 1994 the US was at 13.7% and Canada at 9.7%. Yet as Canadian and American health care financing and health care costs diverged, other factors that might complicate explanations of cost trends remained similar. Medical education remained interchangeable. The cultural influence of the United States on Canada could not have declined, since the influence of mass communication increased. Physicians from the two countries continued to attend the same conferences, read the same journals, and collaborate on research. The United States even created direct pressure on Canada to maintain high physician incomes, through the possibility of Canadian physicians moving south of the border.

In discussing how Canada and the United States pay for medical care and how payers attempt to control those costs, I therefore will highlight the differences between the two countries' patterns and the results of those differences. The conclusions that follow from the Canada-United States comparison fit with a continuum of experience from other nations, and indeed with experience within Canada and the United States themselves.

The most important point is, "sophisticated" health policy analysts tend to pay far too much attention to volume and not enough to prices. The accurate observation that restrictions on the price of services tend to lead to increases in volume should not lead anyone to conclude that controlling prices is ineffective policy. Paying lower prices is much, much better than paying higher ones. There is something a bit bizarre about the assumption that if physicians provide more services in response to lower prices, that is such a bad thing. Experience shows costs are still somewhat lower than with higher prices. Moreover, of all the ways to control total health care costs, methods that provide the public with more services for less money, rather than less services for less money, are likely to be most popular.¹⁰⁸

A second point is, there is a continuum of methods for enhancing price restraints with adjustments that reduce prices if volume rises. Neither Canada nor the United States has employed the strictest versions of such approaches, whose model is German controls on expenses for ambulatory care. But Canadian provinces have moved in that direction, and even weaker versions have, in fact, moderated trends of medical cost inflation when they have been implemented.

A third point is, setting budgets at the level of given providers can be an effective form of cost control.¹⁰⁹ Forms of American managed care can be differentiated in terms of the stringency and targets of their budgeting. As we will discuss further in chapter three, reform proposals in each country tend to involve a search for ways to cap more of spending within a budget. Some of the lower cost increase in Canada than in the United States over time is due to the fact that Canada has been budgeting a large sector of health costs, hospital care. In contrast, American

analysts have dreamed about budgeting a larger portion of costs, through Health Maintenance Organizations, but have in fact budgeted a much smaller sector, because only a small fraction of Americans have been in those plans.

Fourth, restraint on the capacity of the system can help control costs — though one should be careful about assuming that it can always do so in a way that maintains quality of care.

2.1.- Paying for Health Care in Canada

Canada's provincial insurers provide budgets to hospitals and pay fees to individual physicians for specific services.

2.1.1.- *The Logic of Hospital Budgeting*

While hospitals may receive some charitable contributions, and some private payments for services not covered by provincial insurance, the vast majority of their incomes come from the provincial Ministries of Health as part of annual budget processes. As in any budget process, the dynamic in good times is different from the dynamic in bad.

In good times, recipients compete to convince funders that they can accomplish all sorts of good things with surplus funds. A Canadian hospital is no different in this sense from any public agency — even though it is probably not "owned" by the government. In good times the funders may be especially interested in choosing among the nice extra outputs they could get for more money, so want to encourage recipients to explain what they will do with the cash. In good times it is possible to look to the future with optimism, using excess funds for capital investment while not having to skimp on maintenance.

In bad times, recipients are much more interested in talking about output than funders are in hearing about it. Recipients want to explain all the terrible things that will happen if they are cut. If possible, recipients want to rally beneficiaries of their programs to put pressure on funders to maintain spending. The funders want recipients to shut up, accept their fate, and find ways to do more with less. Both the budget or finance officials and the operators within the agency tend to favor short-term operations over capital investment.

Under any circumstances, whoever makes a budget is especially interested in appearing to be "fair," as viewed by both recipients and powerful outsiders (like legislators). In times of conflict, funders are especially attracted to formulae that appear objective and that diminish conflict by limiting recipients' ability to claim relative mistreatment. The norms of "incremental" budgeting therefore are if anything even stronger in "decremental" times. Although policy logic might seem to require cutting by eliminating whole hospitals or programs, normally budgeters constrain spending with some form of across-the-board formula until some severe pressure or golden opportunity allows them to make more targeted cuts.¹¹⁰

Hospital budgeting in Canada is a pretty standard example of these dynamics. Hospitals are quite popular recipients, and therefore especially able to create public pressure for adequate funding.¹¹¹ Historic differences among communities in allocation of medical services, such as concentration of hospital beds in central areas, are continually bemoaned yet, given the objections of established institutions and the norms of incrementalism, corrected only marginally at best.¹¹² For much of the period

since Canada's national health insurance was fully established (1971), provinces paid some attention to hospitals' requests and justifications. It appears that in recent years of fiscal crisis, governments have relied more on their own internally developed allocation formulas and less on submissions from the hospitals. To hospital administrators, provincial budgeting has looked less and less like a negotiation and more and more like an imposition.

2.1.2.- Hospital Operating Budgets

As budgeting officials have produced more stringent budgets, hospital executives and physicians have been expected to do more with less. Since there is little reason to believe that extra throughput will lead to either greater total budgets (indeed, it may be viewed as evidence that the budget could be cut more), one might expect hospitals to do less with less. In other policy areas we do not necessarily assume that agencies will easily become more efficient. In health policy there are continual worries that capped operating budgets will lead to underprovision of services. Yet Canadian hospitals have, in fact, steadily become more efficient: as Robert G. Evans puts it, "the throughput of Canadian hospitals has been going steadily up while bed supply has been going steadily down."¹¹³

It seems useful to speculate as to why results have been relatively positive in this case. Unlike agency executives in most governments, Canadian hospital administrators are not monopolists. If the US Army develops a weapon that does not work, budget oversight may not provide effective sanctions. If the budget is cut there is still no weapon, and political executives presumably wanted a weapon. But if a Canadian hospital spends the money that it has particularly badly, budget officials might shift resources to another hospital. Thus a form of competition within a budget has always operated in Canadian hospital care, even though it was never called "managed competition".

In fact this competition works on two levels. A Canadian hospital needs to worry about satisfying both budget overseers and, as Evans has pointed out, its own physicians. As in the United States, but unlike in many other countries, physician services in Canadian hospitals are provided largely by non-salaried "admitting physicians" who receive separate fees per service. The doctors therefore have a substantial interest in maximizing hospital throughput, and Canadian hospital administrators, like American, have to worry somewhat that dissatisfied physicians will switch their practice to another institution. Doctors therefore will press for efficiency both through "voice" in hospitals' internal counsels and through the threat of "exit." Administrators, in turn, can insist that the various services find ways to increase efficiency, for that is in the physicians' own interest. Thus, in one hospital that I visited, the need to live with constrained budgets caused the cardiologists and cardiac surgeons to reassess procedures and prioritize cases.¹¹⁴

The incentives for efficiency in Canada may be contrasted to those in the United Kingdom. In the UK, given the more limited supply of facilities, hospitals are more likely to be in essence monopoly suppliers to the government (the National Health Service). This was true when hospitals were officially divisions of the NHS, and is still true now that they are ostensibly independent contractors to the NHS. If a relatively-monopoly institution performs poorly, payers have little way to change its behavior. There seems to be a **paradox of competition: in order for competition to increase efficiency, there must be some slack in the system.** If there were no slack then the disciplines of competition — such as allowing a provider to go out of business — could not be allowed to operate.¹¹⁵

In the UK also, salaried hospital specialists have had little or no incentive to increase their output within the hospital budgets. Not only has their income not depended on hospital efficiency but, because British specialists who take government money can also do a substantial private business, these physicians even have had incentives to reduce hospital output for public patients — something for which budget cuts give them an excuse!

In short, the economic incentives in the Canadian system, as opposed to the United Kingdom's, reward rather than punish greater productivity by physicians within the public scheme. One should not overemphasize the importance of economic incentives. The fact is that throughput has increased in the NHS as well. Physicians do have professional pride, and hospital administrators, whatever the immediate incentives, do tend to have an interest in providing hospital care. Moreover, technological innovations such as new forms of anesthesia and of less invasive surgery increase the capacity to provide services, regardless of the form of payment. Thus the move towards more outpatient surgery is a worldwide phenomenon. But if one is looking for institutions that would reduce the incentive for service reduction within a capped budget, Canada's approach seems a good model. The difficulty is, it may depend on conditions that cannot be replicated elsewhere. Thus the form of hospital staffing could not be created in Germany or Japan, while the underlying large capacity that enhances competition is absent in poor countries. Ironically, the United States, with its combination of high capacity and admitting physicians, is the nation that could most easily adopt Canada's dynamic!¹¹⁶

2.1.3.- Hospital Capital Budgets

Canadian provinces have long been involved in a form of capital planning, deciding where to build new facilities, where to place expensive new equipment, and where to eliminate capacity.

Neither these nor any other budgetary controls lead to lower spending except when political pressures support that. Thus in Canada, as elsewhere, there have been periods of relatively thriving economies and desire to expand, during which spending has increased quickly. In Canada that indeed has been the norm.

Nevertheless, Canadian provinces have regulated the purchase of new equipment strictly enough, compared to the weak planning structures in the United States. Even if a hospital is able to raise private funds for an investment, the provincial Ministry of Health can block its acquisition by refusing to increase the hospital's operating budget to pay for running the equipment. As a result, high-tech capital equipment in Canada, such as MRI machines, tends to be concentrated in academic medical centers and used much more intensively than in the United States. Both the costs of the machines and the salaries of their operators are spread over more uses, resulting in lower costs per use.¹¹⁷

Different levels of prestige and ability to offer the Ministry a deal by leveraging its money with private funds ensure that some hospitals have advantages in the competition for funds. Political pressures surely mean that sometimes facilities are built in places where some planners would prefer they not be built. Yet the gap between the product of Canada's political processes and the "best" allocation is likely to be much smaller than the gap between that allocation and the result of American market-dominated processes. One test is the actual results: clearly the United States has much greater capacity in ways that lead to higher costs but, in many cases, not obviously better services.¹¹⁸ Another is a matter of logic. To the extent that the most prestigious hospitals are favored, that is only a problem if they are not prestigious for

good reason. To the extent that politicians seek to spread spending around, in a democratic system, that means facilities follow the population. So long as the overall total is adequate and not excessive, the tension between constituency and prestige forces is likely to produce an allocation that is reasonable if not perfect. In contrast, American capital allocation processes, as explained below, favor richer populations over poorer and have tended to overinvest.

As budgets have become tighter, governments have also become more willing to close down politically popular capital plant, whether that be rural hospitals in Saskatchewan or an urban hospital in Vancouver.¹¹⁹ Governments **are** capable of closing hospitals. But they would certainly prefer not to: to wait until it is obvious that a given facility is getting very little use, or until all claimants are convinced that somebody has to pay and are relieved if it is somebody else. Unfortunately, objective information to justify such decisions, outside of extreme cases, is hard to find. After all, the losers normally can invent some sort of counterargument that sounds plausible to nonexperts.¹²⁰

2.1.4.- Ambulatory Services

Unlike hospitals, Canadian physicians have historically been reimbursed per service delivered. Their fees are established in fee schedules set by each province. Originally based on pre-existing charges from physician-dominated insurance schemes, these schedules have evolved, in each province, through a complex semi-bargaining process.

Basically there are three choices involved in any fee schedule. The first is the relative incomes of types of providers. Given that different specialists perform different procedures, the relative values of the fees will determine those relative incomes. The second choice is what services to reimburse. This involves the effective scope of the benefit package, and some arguments about medical effectiveness. It also means that any fee schedule is inherently unstable: over time enough new procedures will be invented that some must be included and the rates will be controversial. Last, fee schedules involve choices about total spending. Given any set of relative values, which can be expressed on a point scale, total spending then depends on the conversion factor — how much is paid per point — and the expected volume of each procedure.

Some health economists and American policymakers would prefer to believe that fee schedules can be set in a rational, objective manner. At best that is only true for the relative values, not the conversion factor. Under American political conditions, devising a "resource-based relative value scale" may be a politically useful exercise.¹²¹ But in Canada, as is normal internationally, fee schedules have been set explicitly as modifications of previous schedules.¹²² Provincial governments have tended to be more interested in controlling the conversion factor, and relatively willing to let the doctors fight out the relative values among themselves. "Indeed," in the words of Jonathan Lomas and colleagues, "the relative value of fee items has been, in most provinces, a jealously guarded determination of the medical association."¹²³

Canadian analysts have long been aware that limiting increases in fees did not translate into equal restraint of ambulatory care costs. Even in the early 1970s, Quebec implemented some modest restraints on physicians' overall incomes: General Practitioners who earned more than a target in a given quarter received only 25 percent of average fees for further services.¹²⁴ These measures, however, tended to be quite weak. It is only in the 1990s that the provinces have extensively implemented measures that penalize the physician community with lower fees when total spending exceeds some target.

Nevertheless, the fact that Canadian price controls on physician services were weak enough to allow substantial increases in Canadian costs did not prevent them from being strong compared to American measures. Large differences in Canadian and American price levels are a major reason for the difference in the two systems' overall costs. Over two decades, Canadian fees per service fell to 59 percent of the fees paid by American Medicare and, as best could be determined, less than half of the fees paid by average private insurance plans.¹²⁵ Even with higher volume in Canada, the fee differences are reflected in comparative statistics that show much larger differences in Canadian and US physician expenditure statistics than for hospital expenditure.¹²⁶ Canadian methods of setting fees for ambulatory care also kept inflation below Canada's own levels for pharmaceuticals and dentistry, where prices are largely set in the market.¹²⁷ At a minimum the data shows that, relative to the US, Canadian methods of ambulatory care cost control through fee-setting were at least as superior as Canadian methods of hospital care cost control through budgeting. That may say more about American failures than Canadian successes, however.

Canadian physicians' incomes did not fall as much as their fees, relative to American doctors, because practice expenses in Canada are lower and volume of services higher. But the difference in incomes, as should be expected for two countries with similar numbers of physicians per capita, is close to the overall difference in costs.¹²⁸ Put simply, restraining prices restrains incomes. How much medical care a society can afford depends in part on how generously it chooses to reward medical care providers. Canadian physicians objected to the effects of lower fees, and their organizations generally supported "extra billing": the right of physicians to charge more than the set fees to those patients who were willing to pay. Concerns about how that could lead to unequal treatment led to passage of the Canada Health Act, which added the provision for "accessibility" — no extra billing — to the system's basic principles in 1984. Doctors protested strenuously, including with a physician strike in Ontario in 1985, but failed to change the policy.

In the 1990s just doing better than the United States has not been deemed sufficient, and Canadian governments have tried first to stop the growth of their health spending as a share of GDP, and now to shrink the health care share. Within the government programs there are three basic strategies: tighter hospital budgets; modifications of physician payments in ways that limit total spending more directly than simple fee-setting; and shifting of costs to the private sector.

Tighter hospital budgets do not directly require changes in how the budget process works. However, as will be discussed in chapter three, devolution of budget-making power to regions attracts people who want to cut hospital budgets but believe either:

- That local bodies can cut yet do less harm by coordinating hospital care with other activities, such as home care; or
- That local bodies, not the provincial government, would get the blame.

Or both. The depth and effects of devolution efforts vary by province, but the evidence certainly does not support any claims that structural changes are nearly as significant as the more parsimonious attitude in provincial governments.

Modifications of physician payment and shifting of costs to the private sector require more distinct, and in some cases related, reforms. The basic issue is how to achieve predictable spending when fees are paid for individual services, and volume of services is not directly controlled. (Controlling volume directly would be "managed

care"). In essence, fees must be on some sort of sliding scale so that they go down as volume goes up.

Provinces' approaches may be divided into two types. One is to limit the earnings of individual physicians. Spending on physician care naturally cannot exceed the sum of what all doctors are paid. Caps can be hard — no payment above a certain income — or soft — reduced payments per service. Thus in Ontario in 1995, physicians would be paid the full amount up to gross billings of \$C404,000 in a year; two-thirds of the standard fees for billings that raised the gross to \$C454,000; and one-third of any billings afterwards.¹²⁹ Although such measures provide an incentive for some doctors to limit their activity, they have no immediate effect on any physician whose previous billings are well below the target. Moreover, since physician incomes vary substantially and a target near the average would be extremely unpopular (not to mention confiscatory on the more successful so perhaps more popular doctors), the target will affect only a small minority of physicians in any province.

The second approach is to set a target for total spending, set presumptive fees, and then adjust the fees downward as soon as possible after determining that spending is coming in above the target. The strength of such measures depends on two factors: the spending target and the speed of the feedback.¹³⁰ Canadian provinces have in different ways moved towards the kind of quick and decisive adjustment adopted in Germany in 1985. In New Brunswick, for instance, fees in one quarter will be cut by an amount calculated to take back from physicians any amount paid in excess of the target for the previous quarter. In the last two or years the measures adopted, when combined with targets that have been rather strict, helped stop the growth of health care spending as a share of GDP in Canada.

Such a system means the province and the physicians are not negotiating set fees, but something more like a budget. It also creates new problems and incentives within the medical profession. Overall limits on income would be objectionable enough. But when increased volume feeds back into lower physician fees, either some doctors perform more procedures, others don't, and the first group takes income from the second. Or, (almost) all doctors do a lot more work for very little more income. In either case the volume of physician services poses governance issues for physicians themselves: they have a stake in regulating volume. As Barer, Lomas, and Sanmartin nicely express the case, "The 'zero-sum' nature of global expenditure caps clearly focuses physicians' attention on 'the medical commons.'"¹³¹

The new pressures only increase both physicians' and budget-makers' interest in extra-billing, which would limit the provinces' payments while allowing doctors to maintain their incomes by getting extra payments from patients who were willing to pay. Since that directly violates the Canada Health Act, attempts to create a zone of extra private income for physicians so far have focused more on "delisting" services: in essence deciding that certain services are not "medically necessary," so the provinces won't pay and physicians can charge what they wish. The trick, of course, is to find services that can be sold to the public in political debate as "unnecessary" but that lots of the public might be willing to pay for — such as sonograms absent certain indications during pregnancy, or surgical removal of benign skin lesions and warts, or higher-priced versions of high blood pressure medication (the lower-priced items being covered).¹³² Whatever the difficulties, the covered services are becoming more explicitly part of the overall negotiations between doctors and the government in each province, as physicians try to limit the coverage of a cap on payments in return for accepting its enforcement.

More stringent and definite caps on physician incomes also have raised current physicians' interest in restricting the number of new doctors competing to share the limited pie. Thus more stringent budgeting of physician care has changed the politics of physician supply, making restrictive policies more plausible. Moreover, the medical associations have no easy ways to prevent a volume "arms race" among their members, which would lead to all working harder to no avail. In this context the prospect of some sort of fixed budgets based on capitation may not look so forbidding. At least physicians would not feel pressured to do more or lose income. Since health policy analysts have always had a soft spot in their hearts for versions of capitation, the backlash from new physician services cost controls enhances at least rhetorical interest in Canadian reforms to create some form of managed care. Budgeted capitation may be more attractive than budgeted fee-for-service payment.

That interest has led to many proposals but no real achievements. Chapter three will discuss the obstacles that have made such measures seem radical and unlikely. For now, the key points are that Canada's relatively greater success at controlling health care cost in the 1990s than the 1980s seems to be due to applying previous cost control methods more stringently, rather than through any pathbreaking measures. Hospitals were budgeted more tightly. Fee-control for ambulatory care was enhanced by volume adjustments that are essentially of the same type as those in Germany and in America's Medicare — though weaker than the former and stronger than the latter. These measures did, however, increase the pressures to follow a third and equally uninnovative approach, reducing insurance coverage. As a transfer of costs from the government to private accounts, this normally helps the government budget. Whether it would lower total costs is more dubious. Obviously physicians hope it does not!

2.2.- Paying for Health Care in the United States

How health care is paid for in the United States depends on who is doing the paying.

With the exception of a small number of prepaid group health plans — such as Kaiser-Permanente, Group Health of Puget Sound (Seattle), and Group Health Association (Washington, DC) — physicians and hospitals in the 1960s were paid "usual and customary" fees per service by local insurers. When the Medicare program was created, it adopted that payment mechanism, paying different fees in different markets rather than one national schedule.¹³³

Over the past three decades there has been some growth of the Kaiser-style traditional Health Maintenance Organization, which owns its own hospitals (or in essence rents a block of beds), and pays physicians either a salary or a proportion of the organization's net earnings.¹³⁴ But the most important change has been a dramatic growth in other forms of payment, such that the idea that insurers would pay some "usual and customary" rate has almost disappeared.

Instead, individual payers negotiate fees with individual providers and promote a wide array of other contract provisions designed to ensure that increased volume does not cause costs to soar too high. For many years the result of this evolution was mainly to create complexity. Competition and innovation in contracting did not produce policies that controlled costs nearly so well as the direct regulation in the Canadian system. Recently American methods have become more successful than before, but as

the Canadians have tightened their own measures, the gap between spending levels in the two countries still has not narrowed.

Given their variety, American cost control efforts must be divided not only by sphere of spending (hospital vs. ambulatory) but by payer (public vs. private) and especially by type of approach (unit of payment, "management" vs. discounting, and type of contract).

2.2.1.- Units of Payment in American Health Care

The first big difference between Canada and the United States is, in the United States most providers receive different levels of payment from different payers for the same services.

An American hospital will create a standard set of fees for its services. It will even report, on its accounting documents, how much it would have received if it had collected those fees for all services. They call this "gross receipts". But they collect these fees from virtually no one, and these fees bear no relation to actual costs. Thus Stanford University Hospital one year counted \$603 million in "gross receipts" but collected only \$312 million — and stayed in business.¹³⁵ Not only do hospitals discount their prices to many payers, but they also charge according to different categories. The Johns Hopkins Hospital, for instance, in 1993 had eighteen thousand charge categories for payment by five hundred different insurance plans.¹³⁶

The biggest difference for most hospitals is between how they charge most private payers, in essence as fees for individual services on top of a day rate, and how they charge Medicare, which is mainly as a fee per diagnosis. But hospitals owned by group- or staff-model Health Maintenance Organizations in essence charge by capitation (being budgeted for a share of the premiums for the members of the HMO), and insurers increasingly are trying to negotiate capitated payments with individual hospitals for all or some subset of their members' hospital services.¹³⁷

Also unlike in Canada, a hospital may be allowed to charge more than what the insurer will pay, and to collect that from the patient. It depends on the contracts between each beneficiary and her insurer and each insurer and the hospital. If an insurer refuses to reimburse a hospital for some service then the hospital will insist on collecting from the patient (normally when one is admitted to a hospital, one signs a form both authorizing the hospital to bill one's insurer and acknowledging one's own personal liability for the charges).

American physician care is paid by an even more varied set of arrangements. Some doctors receive salaries or shares of revenue within capitated group practices. But most individually or as a group contract with a wide variety of insurers, at a wide variety of rates. Each payer seeks a discount from the rate the physician wants to charge. Whether that discount actually represents a savings compared to the average that the doctor manages to extract from all payers is another matter. But many contracts between American providers and payers involve far more than price.

2.2.2.- Managed Care and Discounts

Rather, some contracts allow payers to (try to) regulate the volume of care, as well as its price. What policy advocates call "managed care" actually involves three distinct forms of cost control.

The first method of managed care is to set rules about which specific procedures will be reimbursed under what circumstances, administered by some regulatory bureaucracy. This **utilization review** may be enforced either by refusing to pay for services that did not meet the standards or, more fairly, by requiring approval in

advance for certain procedures. For example, a plan may require that hospitalizations be approved in advance except for emergencies, which would have to be approved within 24 hours after admission.¹³⁸

Utilization review is useful inasmuch as it provides a sentinel effect, making physicians think twice about ordering services, and to the extent that it is possible to apply general rules to specific medical cases. But the fact that review depends on clearing treatment with nurses or clerks who are at the other end of a telephone line and never see the patient creates immense frustrations and distrust.¹³⁹ Physician practices need extra staff to keep track of each payer's utilization rules and arrange approvals, in addition to the extra labor involved in keeping track of all the different payers' prices. Patients are told that insurance company bureaucrats objected to their personal physician's professional judgment.¹⁴⁰ And the cost of careful review is such as only to be justified for more expensive procedures.

For all these reasons utilization review is not very popular with doctors and has proven useful for only a limited number of applications: above all, hospitalization for elective services. Managed care organizations are even beginning to rethink some of their referral requirements.¹⁴¹ But that application was associated with substantial drops in admission rates, so now virtually all American insurers employ some sort of review procedures, at least for admissions.

The second form of managed care is **prepaid group practice through the traditional group- or staff-model health maintenance organization**. Patients contract to pay a lump sum for comprehensive care from a group of providers. The providers practice together in one or more multispecialty clinics, providing virtually all services from within the group (there may be occasional referrals outside for highly specialized care). The physicians only treat members of the HMO, and the HMO members only receive care from those physicians.

The traditional HMO is a large organization whose providers bear risk **collectively** for the cost of services to the members. Physicians have incentives to satisfy patients but not to prescribe lots of tests and services, because the former adds to the group's income and the latter only adds to its costs. Review of practice is less a matter of set rules and more a matter of collective pressures. Historically, these HMOs maintained their cultures both through internal socialization and through selecting physicians who wished to practice that way. They have tended to emphasize preventive medicine more and lots of tests on sick people less. In a number of studies they have been shown to control costs better than unmanaged fee-for-service systems, with comparable quality of care.

American health policy analysts have had a love affair with traditional HMOs for a long time, and the federal government has been trying to encourage them since the early 1970s. In fact, however, the growth of "HMOs" in the United States in recent years has little to do with the traditional model, because that model has severe competitive weaknesses. First, it provides the narrowest choice of physicians, and therefore seems very restrictive to potential patients, who value choice of doctor highly. Second, clinic-based organizations inevitably have capacity difficulties. Patients must travel to the central clinic, rather than to individual offices closer to their homes or places of employment. The need to build new facilities to expand capacity means the HMO is likely to have either excess capacity, raising its costs per patient, or too little, resulting in longer waits for care. Third, expanding a traditional HMO requires substantial capital investments building or expanding facilities, as well as hidden human capital costs socializing new physicians. These higher capital costs mean that even if they are more efficient in operation, traditional HMOs are less efficient as an

investment. Fourth, unless the HMO has an extremely good local reputation, prospective customers may be discouraged by the prospect of not being allowed to get services from the most prestigious local providers — something that may seem unimportant to policy analysts but seems more important to normal citizens who want insurance so that, when in danger, they can be sure of the "best" care possible.

Therefore a third form of managed care is becoming much more significant in the United States. In essence, it involves arranging for some physicians or group of physicians to accept a capitation rate not just for care that they provide themselves (as in the traditional HMO), but for care that they prescribe from others. A physician therefore functions as a **risk-bearing gatekeeper**: he decides whether a patient will get certain services, and has an incentive to limit those services in order to minimize risks to his own income.

The risk-bearing gatekeeper approach is hardly unique to the United States. The reforms of Britain's National Health Service include creation of "GP Fundholders": general practitioners who hold budgets from which they are expected to pay for all of certain types of services for the patients on their lists. In Germany, physicians now may forfeit personal income if pharmaceutical costs for their patients exceed a standard. Displacing risk from the insurer to a primary care physician serves many purposes. It puts responsibility for rationing in the hands of a physician who sees the patient, rather than doing so through general rules enforced by a distant bureaucracy. It also allows displacement of risk to providers, as in the traditional HMO, without requiring that patients limit their choice of primary physician, and without requiring comparable capital investments. All an insurer need do is convince enough physicians to join its network.

Yet American implementation of risk-bearing gatekeeping has some dangerous aspects. A primary care physician may be at much greater risk than in the British or German systems. In Britain the risk only applies to a small portion of hospital bills, and in Germany only to pharmaceuticals, while in the US the point, for payers, is to put as much costs as possible in the hands of the primary care physician. Moreover, physicians can contract for much smaller pools of patients in the United States. An American solo-practice physician might have a number of separate contracts, each for a small number of patients. Thus one noted American health policy scholar has 100 patients through one HMO and 130 from a second.¹⁴² Under such circumstances a doctor can easily be penalized or lose a bonus for entirely random reasons. Putting a doctor at risk for the costs of small pools of patients contradicts the logic of insurance in the first place, which is to spread risk widely. When patients are paid for from a large group, a doctor can treat according to accepted standards of care and assume that costs across that large number of patients will even out. When patients are divided into small groups, a doctor may be punished for costs in the group where they happen to show up, yet not rewarded where they do not.

We have no more than anecdotal evidence that the new American forms of risk-bearing gatekeeping cause physicians to underserve their patients. But we do know that logically they create that incentive, and physicians worry about that. We also know that in a world in which primary care providers are expected to bear much of the risk for secondary and tertiary care, large group practices are much safer for physicians (and maybe patients!) than small or solo practices. At 100 patients per doctor, a group of twenty doctors would have 2,000 patients in a given contract — a safer amount.¹⁴³

Utilization review, group- or staff-model HMOs, and placing risk on gatekeeper physicians are three distinct ways to manage care.¹⁴⁴ They can, however, be combined. Utilization review may be used within a traditional HMO, and an insurer may contract

with doctors in a way that applies utilization review to some services while putting them at risk for the total costs of others.

Moreover, the organization of medical practice in the United States creates situations that to the insurer look like one system but to the patient may look like another. Consider a very large multispecialty group practice with multiple insurance contracts, such as the George Washington University Medical Faculty Associates in Washington, DC. Such a practice may accept capitated contracts from a wide array of insurers. A patient (such as myself) may be willing to get all services within the group, and the physicians will refer within the group as a matter of course. From my perspective, when I used GWU-MFA as a member of the Capital Care "Network HMO", GWU-MFA was just the equivalent of a group- or staff-model HMO. I went to the clinic and received care. From the overall system perspective, GWU-MFA was like a traditional HMO that charged different prices to different customers. Although one might say its risk pool was divided by having the different insurer payers, that is not very different from a traditional HMO charging different prices to different employers. But GWU-MFA, unlike the Kaiser group practice, also acted in some contracts as a traditional fee-for-service provider.

In a network HMO, providers are united not by being part of a single organization that includes all their patients, but by the facts that they all have contracts with a separate organization ("plan") that supplies each of them with a proportion of their patients; that plan either requires or provides strong incentives for its beneficiaries to receive services only from that "network" of providers; and that plan looks somewhat like a traditional HMO to its members in that it provides care with very little costsharing. Capital Care customers, for instance, are not billed by service except for small copayments, e.g. \$5 for a visit to the primary care physician and \$10 to see a specialist, for visits to any member of the network. From a patient's perspective the major difference, if he goes to a large group practice, is that someone outside the practice will have to approve many referrals. The attraction of a network from the patient's perspective is that, compared to the traditional model, it may offer a much wider choice of providers. The network organizer, however, has to employ a mix of cost management methods: utilization review for hospital services, risk-bearing for GP practices, and in essence traditional HMO collegial pressures for those patients who get their care from a large group practice. From the insurer's perspective, the plan's performance depends on the operation of all the different forms of management.

Another common form is the "Preferred Provider Organization." In a "PPO", patients pay much lower costsharing if they get their services from a special list of doctors ("in-network") than if they go outside the network. But the contractual relationships between the insurer and the doctors within the network will vary from PPO to PPO. Or, something that calls itself an HMO may provide members the option of getting services from non-HMO doctors or hospitals, but again with much higher costsharing (a "point-of-service," POS, option). Again, what that means to either patients, physicians or the insurer depends on the actual contractual terms and forms of management: the stringency of utilization review, distribution of risk, and availability of a large group practice.

While there may be affinities, there is no necessary relationship between many of the ways that plans offer services to patients (network HMO, PPO, POS, etc.) and the ways the plans actually manage care (capitated group practice, utilization review, and risk-bearing gatekeepers). Both American analysts and foreign reformers therefore should focus on the actual forms of management and not pay attention to arguments that a particular set of initials represents the "right model" for managed care. They

also should be aware that "managed care" has many possible meanings: it is not "good" or "bad" in itself.

But in American policy debate, the term "managed care" has slowly come to be associated with a distinction which does not in itself involve management at all. In this usage, managed care plans are those,

"whose defining characteristic is their reliance on restricted networks of providers. Enrollees who use providers outside the network are either not covered at all by their insurer or must pay a significant share of their medical expenses out-of-pocket. This definition of managed care includes HMO, preferred provider organizations and point-of-service plans, while excluding indemnity insurers that employ utilization review but not restricted provider networks."¹⁴⁵

The problem with this definition is, it does not fit the ordinary English meanings of the terms "manage" and "care." Restricted networks could be created without any management of care at all. But this definition does identify a key area of controversy about managed care in the United States, and a key distinction between American and Canadian methods of cost control.

The difference is not, as the rhetoric might suggest, between managing the prices of or capacity for care, on the one hand, and ensuring the appropriateness of care, on the other. These objects of control could all be addressed in either system. Instead, the difference is between coordinating all (or almost all) payment, as in Canada through having a single payer, and having a series of selective contracts between insurers and subsets of the provider population, as occurs in the United States.

An American intermediary payer, whether it be a government or an employer or an insurance company, seeks the **power to manage care** from **selective contracting**. In essence it says to a provider, "if you want access to our patients ('covered lives'), you must be willing to accept our terms." Either a government or a coalition of sickness funds that regulates medical practice and payments might seem to do the same thing. But such a nearly universal local payer is different from American competing payers. In the face of political pressures from both the public and providers, the (near) universal payer will virtually always proclaim that any provider that meets the terms is welcome to participate. Moreover, since the (near) universal payer's terms are expected to apply to all or most of the society, they will be expected to be adequate on average: the payer (and the government if there is a difference) will be judged by whether the terms of reimbursement, if applied across the whole system, in fact will maintain politically acceptable capacity to provide care.

The payer in a selective contracting situation does not face the same responsibilities and constraints. But it has four countervailing disadvantages. First, patients tend to want maximum choice of providers. Restricted networks need to offer significant advantages on some other dimension. Second, no payer in a competitive situation has market power analogous to that of the single payer or all-payer alliance in non-competitive systems. Third, even some methods of managed care would work more efficiently in a noncompetitive context.¹⁴⁶ Fourth, any system with multiple payers generates a great deal of extra administrative overhead, as payers must run separate reimbursement systems and providers must meet the costs of dealing with those many separate systems. This difference is a major reason why, in some estimates, American administrative costs for health care are about one percent of GDP higher than Canada's.¹⁴⁷

In order for payment through restricted networks to save money compared to Canadian (or other countries') methods, therefore, a number of conditions must be

met. First, the potential extra savings have to exceed the extra administrative costs — which means actual expenditures on medical care must be significantly less than in Canada or some other comparison country.¹⁴⁸ Then there must be some way to convince patients to accept the restricted networks. Then some combination of two things must come true. Either payers must develop especially efficient ways of managing care, or they must achieve a market situation in which they have more market power than a monopoly payer.

Until the past few years, it seemed that this set of conditions could not possibly be met. In recent years, however, it has proved easier to force patients into the restricted networks. More and more, employers have simply denied their employees a choice. In other cases, they have required much higher financial contributions from employees who refused the more restrictive option. As those approaches have become the norm they have become easier to implement, for employees are less able to justify outrage at the restriction, and employers more able to claim it is a competitive or (for public employers) budgetary necessity. Moreover, as managed care plans gain more market share they become less foreign and more familiar. Since most people are not sick most of the time, it seems reasonable that most people in managed care would have few complaints, and that the idea would become less frightening to the public.¹⁴⁹

Cost trends for private coverage in the United States moderated and for some payers even turned negative beginning in 1994, so one has to ask which of the possible explanations is at work. One factor, clearly, is the move of beneficiaries into more restrictive networks. That may create no more than a small one-time savings, but that would still be a saving. Advocates of managed care may argue that their systems have become much more efficient. But I have seen no obvious examples: no new, innovative techniques. Instead, most evidence suggests that market conditions changed in a way that gave payers the upper hand, so that price competition among providers became much sharper. This occurred even where managed care market competition is quite low. For example, in Columbia, South Carolina, rate increases of 25 percent per year turned into 10 percent decreases. In Houston, Texas, rate increases fell from an average of 14-20 percent to zero.¹⁵⁰

It is not clear why price competition suddenly became more intense in some parts of the country. In part, providers were made nervous and cautious by the Clinton health reform effort (medical inflation has also moderated at other times when "health reform" was a plausible threat).¹⁵¹ In part, certain payers set examples of tough and successful bargaining. Instances include some state governments and pension plans, some coalitions of private employers, and in some cases a single employer (like DuPont in Delaware). In part, the federal government may have shown that the market was slack by successfully imposing stricter fee controls on Medicare physician payment.

Since price competition does not seem to have been created by new efficiencies, one has to ask whether, once having been created by other factors, enhanced price competition can force such efficiencies or, instead, forces inferior service. There is some evidence that in a competitive market, just as in a budgeted health system, constraint forces institutions to become more efficient.¹⁵² There is also evidence that American providers react to constraint in ways that hurt the poor: for instance, by reducing their levels of charity care.¹⁵³

It does appear that the consequences of a given level of payment constraint in America's system of selective contracting are likely to be different from the consequences in Canada. On balance, constraint in single-payer or all-payer systems seems to be applied either across-the-board or in a way intended to maintain a decent minimum of output to all citizens. Thus hospitals are hard to close, but decisions when

made are based on maximizing total services for a given budget. Physicians lose income, but individual doctors are not simply driven out of business.

The point of selective contracting, however, is that some doctors get contracts and others do not. The same is true of hospitals. In each case, a provider may be driven out of business by losing only a portion of contracts, enough to make the overhead unsupportable. Then some payers that wish to buy from that supplier will either be unable to, or have to pay much more. In the United States this concern is shown in worries that selective contracting in the private sector may threaten the viability of "essential providers," such as community health centers and even Academic Medical Centers, which receive many of their funds from government budgets. Governments then will either have to increase their own payments or let those providers go under — neither of which sounds like the ideal form of cost control.¹⁵⁴

American private market experience does not yet show, then, that "managed care" in the sense of selective contracting can improve on Canadian cost control methods. Its cost-control performance has improved, but the gap in system costs between the United States and Canada is still widening. Recent improvements in the fiscal performance of selective contracting seems to be due more to possibly temporary bargaining conditions than to any productive innovations in health care management. It may be possible to create a version of "managed competition" that can equal or exceed the savings from Canada's methods without also threatening to reduce capacity in an inappropriate way. But that has not happened in the United States, yet.¹⁵⁵

2.2.3.- Public Sector Payments for US Health Care

American governments play a rather ambivalent role in health care payment. In a few cases they actually regulate rates paid by private payers (as for hospital care in the state of Maryland). In more cases they will set up systems of cross-subsidies among payers, sometimes working through allowing different rates for different payers (as in New York). But governments affect how American health care is paid for less by regulating other payers than by how the governments themselves pay for care in public programs.

As payers, the federal and state governments are in a contradictory position. On the one hand, they are big payers. Like any other payer, they have an interest in paying less to get more; one may view this also as a responsibility to the general public as taxpayers. Governments have more market power than private insurers have. Yet, unlike other payers, the governments have some obligation to maintain the health of the system as a whole. There is pressure on them not to just get the best possible deal in a way that hurts other payers. Governments have to worry about providers being driven out of business, in a way that private insurers generally do not.

These obligations are not entirely unique to government. For a long time the Blue Cross/Blue Shield systems in many states had a similar position, because they had large market shares and also, as nonprofit institutions that were originally founded by hospitals, a sense of obligation to the medical system as a whole. A very large but not majority payer thus is an awkward position unlike the government in a "single-payer" system like Canada's, or the association of payers in an "all-payer" system like Germany's, or a typical payer in a market with less concentration.

In 1994 Medicare paid for 30 percent of all hospital care; Medicaid paid for 14 percent; and government programs overall accounted for 59 percent of all total hospital costs. Governments paid only 32 percent of physician services, and less in

some other categories.¹⁵⁶ But the levels of payment were high enough to have substantial effects on the market for services from hospitals, doctors, and nursing homes.

In the case of hospital care, governments' and especially Medicare's role has been so substantial that policy takes on some of the attributes of payment policy in a single-payer or all-payer system: federal and state governments must worry about how their payments affect the capacity of the medical care system. That, of course, is why the Disproportionate Share Hospital payment system was invented: as a special subsidy to "essential providers". Medicare also provides special payments to teaching hospitals to subsidize their costs of medical training. For many years Medicare even directly reimbursed hospitals' capital investment costs. In individual states, meanwhile, the survival of individual public hospitals can be a major issue within Medicaid payment policy.

a) Paying for Medicare

For both hospital and physician payment, Medicare controls so much of the market that it was able to institute payment arrangements that were unique among American payers at the time. It has acted as an institutional leader, not follower. Medicare's size not only gives it market power, but enables it to implement measures that would not work so well for individual insurers.

In 1983, Congress passed legislation instructing the agency that manages Medicare, the Health Care Financing Administration, to implement a new system to pay hospitals: the Prospective Payment System for Diagnosis-Related Groups (PPS for DRGs). PPS is in essence a form of fee-bundling. Hospitals are paid according to the major diagnosis that justifies an admission. If their costs exceed the fee, they lose money. If their costs are less, the hospitals make a profit. PPS could be justified in three ways. It simplifies billing from the government's perspective (though the hospital might still generate a list of incomprehensible charges for the patient). It provides hospitals with a strong incentive for efficiency. And, like any process to bundle fees, it limits providers' ability to proliferate services. It is easier to create extra tests for a given diagnosis than to invent extra diagnoses for a patient.

PPS for DRGs has attracted a great deal of attention in the international health policy community. In particular the DRG device offers a way to relate hospital funding to output. It therefore seems more rational than block funding of a hospital budget. Being more rational, however, may be different from being a more effective means of cost control.

In the first place, focusing the debate about costs on outputs may not be the best strategy for third-party payers, whether government or private. In most budgeting situations, it's the claimants, not the controllers, who benefit from talking about all the good that will be done. PPS in particular is also more open to provider manipulation than a global hospital budget, for physicians may make more expensive diagnoses ("DRG creep"). Nor does the system include any protection against an increased volume of diagnoses and admissions. If anything it should lead to more, but less necessary, admissions — since minor cases of a given diagnosis, requiring less care, would be more profitable. In its US implementation, PPS also includes all sorts of exceptions (such as DSH payments). Nor is Medicare's PPS joined, as in Canada's budgeting, to a system of control on capital investments. And, of course, any cost advantages realized by Medicare apply to a much smaller part of services than are covered by hospital budgets in other systems.

Nevertheless, implementation of PPS was associated with a distinct break in Medicare's trend of increasing hospitalization costs. Indeed, even the trend in admissions went down — which cannot easily be explained by theory.¹⁵⁷ It seems fair to say that PPS is a less expensive way to pay for hospital care than allowing hospitals to bill for individual services, and therefore an improvement over the fee-for-service payment that was common in Medicare before and in private insurance since.

Whether PPS is superior to either hospital budgeting or all American private-sector methods of controlling hospital costs is another matter. In the latter case the question is the tradeoff between lower rates (in fee-for-service Medicare) and fewer hospitalizations (with managed care). Although Medicare includes some utilization review, there is little reason to believe that the regional intermediaries who manage Medicare payment, which are private contractors to the system, have as much incentive to manage hospitalization as exists within many private plans.

There is a sensible intellectual case, therefore, for implementing some form of more stringent managed care to limit hospitalizations in the Medicare program. But doing that in a way that actually saves money turns out to be difficult.

Managed care plans can participate in Medicare in a variety of ways. The most common (and for analytic purposes most significant) option is a "Medicare risk contract."¹⁵⁸ Under the terms of legislation passed in 1982 and fully implemented in 1985, HMOs can contract with Medicare to serve patients in a local area for a fee equal to 95 percent of the adjusted average per capita cost (AAPCC) for medical expenditures in that region. The amount is adjusted for enrollees' age, gender, form of entitlement (age or disability), institutional status (e.g. in nursing home or not), and Medicaid eligibility.

Enrollment in these plans is growing rapidly, reaching 4 million beneficiaries in 1996. The balance of evidence, however, says that giving people a choice of plans costs the system money. It appears that the risk-contract HMOs are enrolling healthier patients than the average, so the 95 percent payment is too high. It is not clear whether this difference is due more to risk selection (plans targeting healthier beneficiaries by, for instance, recruiting by holding meetings at restaurants or sponsoring dances) or by adverse selection (people with greater needs choosing to avoid HMOs because they want to maintain a relationship with a physician whom they trust). But the evidence that beneficiaries in the HMOs are significantly healthier than the norm has been consistent and strong. The one exception, a study by Price Waterhouse that was sponsored by the HMO trade association, has been heavily publicized but has at least one major flaw, a quite small sample of risk contract beneficiaries. While it is theoretically possible that some of the difference in health status is due to superior performance by the HMOs, studies have found differences even in preenrollment status.¹⁵⁹

Medicare's risk contract program has flaws in addition to the failure to adequately risk adjust payments. The basic AAPCC data includes the subsidies for Disproportionate Share Hospitals and for Graduate Medical Education. Yet the HMOs seem less likely to buy services from those hospitals, so risk contracting compensates them as if they were paying for something that they are not. It also reduces hospital DSH and GME payments. HMOs also seem to have selectively targeted regions as well. In essence they have contracted in areas of especially high utilization and fees. 15.2 percent of the Medicare population is enrolled in risk contracts in counties where the AAPCC is \$500 per month or higher, and only 0.6 percent in counties with an AAPCC lower than \$300. If the payment rate for risk contracting plans were based on targets derived from standards of utilization and payment that were not driven by local

markets, rates in more expensive markets might allow for larger savings. As it is, however, the rate structure preserves any differences based on higher provider incomes or excessive volume of services.¹⁶⁰

These latter flaws are correctable in theory. Yet if risk selection and adverse selection are occurring, the basic problem of paying more than is appropriate cannot be solved without risk adjustment. Medicare could pay lower capitation rates, but then plans would try to select even healthier beneficiaries, or simply get out of the market. Ironically, the limited available data seems to suggest that Medicare HMOs have reduced the costs of medical care to their members, while providing at least comparable quality of care. But that does not matter: biased selection still cancels out all savings.¹⁶¹ The obvious theoretical response is that biased selection can be avoided by putting all Medicare beneficiaries into HMOs. That, however, faces two major practical obstacles. First, the public would be furious. Second, HMOs of the type with which Medicare has experience are a very small share of the market in most of the country. They do not exist to be joined.

Since managed care has not worked for Medicare, and in any case faces major other obstacles, Congress was forced in the late 1980s to turn to more directly regulatory methods to control Medicare physician costs.

In essence, Medicare acts like a Canadian provincial plan. It covers virtually an entire population: not all persons in a province, but all the Medicare-eligible people in the country. This is, of course, far more people than in any Canadian province. Doctors who want to sell their services to this population virtually have to do so through Medicare. They may choose not to do so, just as in Canada, if they can find enough other customers; but few physicians can forego such a large amount of business.¹⁶² Given this volume and market power, Congress has adopted payment methods for Medicare that are in essence a weak version of the Canadian or German approaches.

First, Medicare adopted a relative value scale for all physician services. This scale was derived in part from research by William Hsiao and colleagues at Harvard that attempted to define the amount of resources such as training and equipment needed for each service: thus, a "resource-based relative value scale" (RBRVS). Although some participants in the process may have believed in the measurements for their own sake, it appears that the appearance of scientific objectivity also helped the American Medical Association leadership to deal with its own constituents as it negotiated with political leaders about the actual contents.**

With that scale in place, Congress can legislate targets for total spending for either all Medicare physician services or subsets of services. At first the targets were divided among surgical, primary care, and other services. Recently the system was changed to eliminate these distinctions.¹⁶³ That does not matter so much as the way a given total is enforced. In essence, if total spending is revealed to have been more than expected after the end of a year (due to greater volume), fees will be reduced to recover that excess in the next year (that is, evidence of higher spending in 1996, established in 1997, would lead to fee cuts in 1998). Conversely, if spending is lower than expected, fee increases will be adjusted upwards.

Because of the lag in enforcement, one should expect these measures to be weaker than those in Canada or Germany. After all, volume could continually be higher than expected. But HCFA can guard against that, in part, with high volume estimates that therefore lead to tight fee increase plans. And in any event, the new system, called Medicare Volume Performance Standards (MVPS) worked very well when implemented in the early 1990s.¹⁶⁴ The most obvious weakness was political. When

volume was lower than expected then physicians, as part of the deal, got higher fee increases. This contributed to a relatively large spending increase in 1994. But that was because the system was working! As one report explained, "Physicians and other professionals were paid a bonus in 1994 that was earned in 1992, and penalties incurred in 1994 for excessive volume increases will be reflected in 1996 rates."¹⁶⁵

Other payers could not implement anything like MVPS for two reasons. First, they have not had the market power to enforce the multiyear targets for fees. Second, they cannot do so fairly. HCFA can honestly claim to know virtually the entire volume of services to an entire class of beneficiaries, and to adjust on that basis. Every other payer has a changing subset of beneficiaries, so cannot claim an objective basis for setting targets.

b) Paying for Medicaid

Traditionally, state Medicaid plans have tried to save money through much cruder methods: simply low fees. Entering the 1980s already with low fees relative to other payers, states could not save much from year to year by making the fees relatively even lower. Indeed, federal legislation, in the interest of making care more adequate, put pressure on the states to bring Medicaid fees closer to local averages.

Therefore, in the 1980s and 1990s, tightening the fee structure in Medicaid, unlike in Medicare, was not a viable cost control method. Meanwhile costs rose especially quickly because Congress expanded Medicaid eligibility for children in a series of steps, while an aging population put demographic pressure on the long-term care portion of the program. States also could not get very far from slashing payments to hospitals, since the hospitals that have large Medicaid businesses tend to be financial wards of the state and local governments anyway, so funds saved from lower Medicaid payments would just have to come from elsewhere in their budgets (perhaps without the federal matching funds!). Regulation of private nursing homes turns out to be something at which states are not very good, especially since nursing home operators tend to be very well connected politically.

Since the methods that work for Medicare won't work for Medicaid, something else had to be tried. One approach was to cheat the federal government out of billions of dollars, and the states, as described in chapter 1, did that. But they still needed some real savings. The logical alternative was to find some way to make managed care work for Medicaid.¹⁶⁶ There were some special reasons to think managed care would make sense for the Medicaid population. First, it was especially likely to use the emergency room for routine services. That may not actually cost the health care system as a whole any money, but it did result in bigger billings to Medicaid than would have occurred if the patients went to office-based physicians.¹⁶⁷ It also represented a possible failure in continuity of care. Without personal physicians who got to know the patients, they would be unlikely to receive useful preventive care, screenings, and management of chronic conditions such as diabetes. Moreover, there was particularly good reason to worry that some of the doctors who were willing to treat Medicaid patients in an unmanaged context were scamming the system by proliferating unnecessary or even fraudulent services. Managed care organizations would, compared to state governments, have more incentive and ability to prevent fraud and mistreatment, as well as to provide preventive and maintenance care. In addition, it would simply be politically easier to force the Medicaid than the Medicare population to accept the strictures of selective contracting. Poor people aren't as powerful as the elderly.

On the other hand, given the low fees that were being paid in many jurisdictions to Medicaid providers, and the prevalence of people with expensive serious chronic conditions on the rolls, one had to wonder why the average managed care organization would want the business, and whether those that took the business would actually provide decent care or simply exploit the beneficiaries by providing too few services, instead of too many. It was one thing to say that good primary care would cut costs through screening, prevention, and disease management. It was another to assume that managed care organizations would have the necessary networks in impoverished areas, or that they could provide continuity of care to a population that, because its eligibility depended on fluctuating economic status, would continually be moving in and out of the program.¹⁶⁸

Nevertheless, given the lack of alternative and distinct encouragement from the Clinton administration, selective contracting is a fast-growing feature of state Medicaid programs. By the end of 1995 there were about 11.6 million Medicaid beneficiaries in managed care networks, up from 3.6 million in 1992. In most states this was on a limited basis: voluntary or in some counties but not others. But all but six states had some version of Medicaid managed care.¹⁶⁹ The record is not unblemished: in Florida in particular some "medicaid managed care" organizations have not performed well. In some cases, such as New York city, it has been difficult to find plans willing to take the business as quickly as the state would like. But, on the whole, the experience has been better than the alternative. States appear to have benefited particularly from the peculiar market conditions of the early 1990s.

In essence, the health care market in the United States at present is a mad scramble for control of "covered lives". Managers of health plans figure that, if they control a larger part of a given market, they can negotiate for better prices from hospitals, doctors, and drug companies. A plan that pays less for service then can charge less for its coverage, get more business, get more market power, and so on in a virtuous circle. Medicaid beneficiaries thus became a valued prize in the contest to gain market share and thus bargaining power.

These developments are quite recent; except for Arizona, state Medicaid managed care plans tend to be no more than three or four years old. Still, it seems that in most cases the reforms are working fairly well. The main difficulty, from states' perspectives, is that the plans do indeed keep people out of hospitals. But many of those hospitals needed the Medicaid money to help cover the costs of treating all the people who don't have any insurance at all. So what will happen to the hospitals?

That brings us to the last important dimension of payment for medical care in the United States: finance of the supply-side.

2.2.4.- Investment in American Health Care

In chapter one we noted that the United States has far greater capacity of some high-tech equipment than Canada has. In this chapter we mentioned that Canada in essence controls investment in hospitals through provincial budgets. It is not exactly a rationally planned system, but the choices follow a sort of compromise policy logic.

Investment in American health care physical plant follows a kind of market logic. Historically that was anything but a logic of fiscal constraint. Hospitals got their business from doctors, their admitting physicians. Admitting physicians did not care what hospitals charged, because the insurance paid that. They did care about having the best equipment to work with. So hospital managers felt they had to have the most up-to-date gizmos to keep their physicians from affiliating with other hospitals instead. There might not be enough demand in an area to justify a Computerized Axial

Tomography scanner in each hospital. But each had to have one. Insurers, who were competing with each other, had no way to cooperate to manage this process. Medicare was created in the heyday of this dynamic of expansion. As part of its political design, it was supposed to reimburse hospitals for their "costs". That sounds fair enough; the trouble is, costs depend on opportunities as well as inputs. Capital investment was obviously a cost; it was factored into the Medicare payment formula, and that encouraged more capital investment.

The result was what policy analysts call the "medical arms race" among hospitals. The federal government did create a structure for capital investment planning at the local level, with "Health Systems Agencies" and a "Certificate of Need" program. But this planning was essentially voluntary, dependent on cooperation by the hospitals, and that was rare. One of the few success stories did not even require the certificate of need structure. In Rochester, New York, two powerful local employers, Eastman-Kodak and Xerox, joined up with Blue Cross/Blue Shield, which insured more than 70 percent of local residents, and the large local hospitals. This consortium controlled capacity in a way that kept Rochester's costs well below the national average.¹⁷⁰ But other communities did not have the same combination of local power structure and farsighted corporate leadership.¹⁷¹

In the 1980s this dynamic began to reverse, somewhat. Medicare ceased to reimburse all capital investment. But hospitals entered the financial markets, borrowing to compete. Slowly, it became clear to many hospital managers that they faced leaner times, and that the issue might be how to manage downsizing rather than how to expand. But that created new financial needs, such as cash for mergers in order to consolidate operations. Government still took no significant planning role. So the movement was not from medical entrepreneurship to planning, but to financial entrepreneurship.

As government programs have begun to tighten their payment policies, and private payers have both demanded lower rates and reduced admissions, the question has become less what hospital capacity will be added than what hospitals will close or merge. That is an unmanaged process, in which the market puts institutions in danger and state or local governments respond if that creates an emergency, and if they have the political will to do so.

Meanwhile, some investors see profits in hospitals if they have strong local bargaining positions. And there is extensive investment in other forms of health care delivery, such as home health networks and nursing homes. All of this capitalism definitely responds to government policy, because policy shapes the profitability of business. If Medicare cracked down on its payments for home health care (as it should), there would be less investment. But there remains in the United States now, as before, no method to relate medical capacity to medical need.¹⁷² The major difference is, the risks are more even now: undercapacity as well as overcapacity.

2.3.- Conclusion

In this chapter we have reviewed major aspects of how providers of health care are paid in the United States and Canada, and how payers attempt to control those costs.

Because they represent the most spending and the major approaches and controversies, we have focused on hospital and ambulatory care. The most fundamental difference between the two countries is, payment in each Canadian

province is structured in a way based on an attempt to control the total provincial expenditure. In the United States, in any given area, different payers are using different measures to control only their own spending.

Because of that difference, much more of Canadian spending can be subjected to measures such as budgeting and expenditure caps. Only the largest of American payers, Medicare, can imitate how Canadian provinces pay for physician services. Universal and coordinated coverage is thus part of the Canadian scheme of cost control, and its absence is one of the reasons for American relative failure.¹⁷³

We need not look only at the difference between Canadian and American methods for evidence. We can also make comparisons within each country. In Canada, as mentioned in chapter one, costs for privately paid services have risen more quickly than costs for publicly paid services. In the United States, Medicare costs have risen more quickly than private sector costs. But that is explained entirely by demographics and differences in benefit packages. Not only has the Medicare population been aging, but in recent years rates of insurance for the non-Medicare population have fallen — a good way to reduce insurance payments, but not a sign of payment efficiency. In fact, per capita spending per enrollee grew more slowly within Medicare than in private insurance for the period from 1969 to 1993 — and much more slowly from 1983-93, the period when Congress got serious about cost control and Medicare implemented PPS and MVPS.

In 1994, Medicare spending did grow much faster than private spending (9.8 percent vs. 4.1 percent). But that was caused in part by one-time factors like the bonus in higher rates that MVPS gave to physicians as a reward for lower-than-expected volume in 1992. Moreover, Medicare covers a different benefit package than private insurance, both because of its exclusions and because Medicare patients have unusual needs (such as more home health services). If we compared costs based only on areas of comparable benefits, Medicare costs in 1994 rose by 5.6 percent per enrollee, and private insurance costs by 3.6 percent. We simply cannot say that this small difference in one year disproves the experience of the previous two decades.¹⁷⁴

This analysis does not mean that the selective contracting of American managed care is useless for countries in Latin America. I will argue in chapter 4 that it may be attractive in certain circumstances, where Latin conditions resemble the United State's more than Canada's, and Canadian policies seem unobtainable. But as a matter of principle, and if one wanted to have universal coverage, the evidence so far says that Canada's payment systems are a better model.

Endnotes for Chapter 2

¹⁰³ As shown by the title of the International Bank for Reconstruction and Development, *World Development Report 1993: Investing in Health* (Oxford University Press, 1993).

¹⁰⁴ See the articles by Enthoven and by Robert G. Evans and Morris L. Barer in OECD, *Health Care Systems in Transition* (Paris: OECD, 1992). See also, David Azevedo, "America's latest export: managed care," *Medical Economics*, December 9, 1996, pp. 71-79.

¹⁰⁵ In 1994 Canada spent 9.7 percent of GDP; the United States spent 13.7 percent. Health Canada, "National Health Expenditures in Canada: Highlights" Table 1; Levit et al, "Health Care Spending in 1994," p. 131. In per capita dollars adjusted for purchasing power the difference, as noted in the introduction, is much greater. Comparisons to other countries are based on the OECD 1993 Database.

¹⁰⁶ Using the OECD's figures for 1980-91, Canada was third in the rate of spending increase as a share of GDP, behind the United States and Finland, and fifth in spending growth per capita (PPP-adjusted), behind Finland, the United States, Portugal and Spain.

¹⁰⁷ For a masterful example of such analysis see Robert G. Evans, Morris L. Barer and Clyde Hertzman, "The 20-Year Experiment: Accounting For, Explaining, and Evaluating Health Care Cost Containment in Canada and the United States," *Annual Review of Public Health* 12 (1991) pp. 481-518. I discuss some explanations that they do not address as fully in the sections of *Competing Solutions* referenced in Chapter One.

¹⁰⁸ For a discussion of why the standard economic arguments against "price controls" do not apply to health care, see Joseph White, "Paying the Right Price," *The Brookings Review* (Spring, 1994) 6-11.

¹⁰⁹ We cannot say budgeting is always more effective than fee regulation for two reasons. First, as in Germany, fee regulation can be done in ways that work a lot like budgeting. Second, as in Japan, it is possible to regulate fees so stringently that volume simply cannot be raised enough to compensate. There are a lot of generalizations about health policy that should be prefaced, "except in Japan." See White, *Competing Solutions*.

¹¹⁰ For a broader discussion of budgeting for health care see Joseph White, "Markets, Budgets, and Health Care Cost Control," *Health Affairs* (12:3) pp. 44-57. For the classic description of incremental budgeting see Aaron Wildavsky, *The Politics of the Budgetary Process* (Boston: Little Brown, 1964). For evidence and an explanation of why decremental times strengthen incremental patterns, see Joseph White, "(Almost) Nothing New Under the Sun: Why the Work of Budgeting Remains Incremental" in Naomi Caiden and Joseph White eds., *Budgeting, Policy, Politics: An Appreciation of Aaron Wildavsky* (New Brunswick, NJ: Transaction, 1995).

¹¹¹ See Robert G. Evans, "Health Care Reform: 'the Issue from Hell'" *Policy Options* (July-August 1993) pp.35-41.

¹¹² Thus when provinces review their health systems, the need for increased planning is always cited. Again, there is nothing Canadian about this; I have on my office wall an article about a commission calling for rationalization of the hospital distribution in the London metropolitan area — in 1892!

¹¹³ Robert G. Evans, "Managing Health Reform in Canada," in Monique Jerome-Forget, Joseph White, and Joshua Wiener eds., *Health Care Reform Through Internal Markets: Experience and Proposals* (Montreal and Washington: Institute for Research on Public Policy and Brookings, 1995) p. 221.

¹¹⁴ Here I go beyond Evans' argument in *ibid*, based on my interviews and observations, but the basic point about physicians and hospitals is his.

¹¹⁵ See the account of reform in the U.K. in White, *Competing Solutions*.

¹¹⁶ Hospital budgeting per se, of course, is common. Canada is different in the underlying organization of hospital services combined with the budgeting. It did not choose this approach, but stumble into it. Use of admitting physicians is simply an historical inheritance, as is the level of capacity that allows meaningful competition.

¹¹⁷ See Robert G. Evans and others, "Controlling Health Expenditures: The Canadian Reality," *New England Journal of Medicine*, March 2, 1989, pp. 573-74; Morris L. Barer, "Hospital Financing in Canada,"

Discussion Paper HPRU 93:6D (University of British Columbia, Centre for Health Services and Policy Research, April 1993); Donald A. Redelmeier and Victor A. Fuchs, "Hospital Expenditures in the United States and Canada," *New England Journal of Medicine*, March 18, 1993, pp. 775-77.

¹¹⁸ These include not only the higher prices per test mentioned in Redelmeier and Fuchs, *ibid*, but cardiac surgeries performed in units where there is too little business to maintain maximum quality, and an unusual portion of bone marrow transplants performed for persons for whom they are less likely to help. On the latter example see U.S. General Accounting Office, "Bone Marrow Transplantation: International Comparisons of Availability and Appropriateness of Use," GAO/PEMD-94-10 (March, 1994).

¹¹⁹ Thus 52 rural hospitals were closed in Saskatchewan in 1994-95; in Vancouver University Hospital's Shaughnessy site was closed and its University of British Columbia site was merged with Vancouver General; in Winnipeg ophthalmology services were consolidated from two sites into one. For a variety of examples from around the country see *Maclean's*, Dec. 2, 1996, pp. 58-68.

¹²⁰ Carolyn Tuohy, "Health Reform, Health Policy - Towards 2000: Canada in Comparative Perspective" ms. prepared for the "Four Country Conference: Health Reform, Health Policy - Towards 2000", Montebello Quebec, May 16-18, 1996. pp. 6-7.

¹²¹ See the account of RBRVS in David Smith, *Paying for Medicare: The Politics of Reform* (New York: Aldine de Gruyter, 1992).

¹²² See Victor G. Rodwin, Harvey Grable, and Gregory Thiel, "Updating the Fee Schedule for Physician Reimbursement: A Comparative Analysis of France, Germany, Canada, and the United States," *Utilization Review* 5:1 (February, 1990) pp. 16-24.

¹²³ Jonathan Lomas, Cathy Charles, and Janet Greb, "The Price of Peace: The Structure and Process of Physician Fee Negotiations in Canada," Working Paper 92-17 (McMaster University, Centre for Health Economics and Policy Analysis, August 1992) p. 184. Sometimes, however, the relevant medical association's efforts fail. Thus in British Columbia a thorough revision of relative values was explicitly left to the Medical Association, in Article 13 of the master agreement between the province, BCMA, and the Medical Services Commission (Victoria, B.C., October 1993). But, in a series of steps, the process collapsed, as explained in an internal ministerial "Briefing Note" dated July 12, 1996.

¹²⁴ Morris L. Barer, Robert G. Evans, and Roberta J. Labelle, "Fee Controls as Cost Control: Tales from the Frozen North," *Milbank Quarterly* 66:1 (1988); Lomas et al, "The Price of Peace."

¹²⁵ Comparisons to private plans are difficult because there is such a wide variety of such plans. Moreover, many plans pay on different bases: according to different service definitions, or capitation, or some other "bundled" payment. Even when comparing to Medicare, differences in classification mean that a substantial minority of services cannot be compared. Nevertheless, the finding of large difference is robust across a large number of comparisons. In fact it seemed to have widened by the time of W. Pete Welch, Diane Verilli, Steven J. Katz, and Eric Latimer, "A Detailed Comparison of Physician Services for the Elderly in the United States and Canada," *Journal of the American Medical Association*, May 8, 1996, pp. 1410-16; for the services they studied, an index of all fees in Canada was 46 percent of the Medicare level. See also Welch, Katz, and Stephen Zuckerman, "Physician Fee Levels: Medicare Versus Canada," *Health Care Financing Review* 14:3 (Spring, 1993) pp. 41-54; Katz, Zuckerman, and Welch, "Comparing Physician Fee Schedules in Canada and the United States," *Health Care Financing Review* 14:1 (Fall, 1992) pp. 141-49; Victor R. Fuchs and James S. Hahn, "How Does Canada Do It? A Comparison of Expenditures for Physicians' Services in the United States and Canada," *New England Journal of Medicine*, September 27, 1990, p. 886.

¹²⁶ The OECD 1993 data base reports Canadian physician expenditures as 1.4% of GDP and American as 2.2%; Canadian hospital expenditures at 3.6% of GDP and American at 4.0%. One has to wonder, however, whether some services, such as imaging and oncology services, are being billed in-hospital in Canada but outside in the U.S.. See Welch, Verilli et al, "A Detailed Comparison," which both refers to greater differences on physician than hospital spending at p. 1410, and yet mentions the difference in billing on p. 1411.

¹²⁷ Tuohy, "Canada in Comparative Perspective," p. 9.

¹²⁸ Practice expenses are lower, of course, because Canadian doctors deal with far fewer payers and virtually no "managed care". Net incomes in the early 1990s were around 2/3 or 3/4 of American levels. See White, *Competing Solutions*, p. 68 and elsewhere.

¹²⁹ Morris L. Barer, Jonathan Lomas, and Claudia Sanmartin, "Re-Minding Our P's and Q's: Medical Cost Controls in Canada," *Health Affairs* 15:2 (Summer, 1996) p. 223. That article provides a more thorough account of the ground covered in this section of the report.

¹³⁰ If a payer set fees in such a way that the projected spending were 110% of the previous year's total, then no enforcement process could result in lower spending. On the other hand, if a payer set fees to yield spending 90% of the previous year's total, but the enforcement were to cut fees two years later by ten percent from a figure that had not been negotiated yet, physicians would realize the income from whatever extra volume they managed to create. In comparing two systems one therefore must compare both the targets — fees times expected volume — and the enforcement — how quickly the payer could clawback any excess from higher than expected volume.

¹³¹ Barer, Lomas, and Sanmartin, "Re-Minding Our P's and Q's," p. 221.

¹³² The first example was cited to me during interviews in British Columbia in late 1993; the others were established in 1996; see *Maclean's*, December 2, 1996, p. 58. On the benign skin problems, the agreement was that, if the government did not implement this coverage change, it would raise the targeted total payments to physicians by C\$7.1 million, the projected cost of those services. (As described in an internal briefing note of the Ministry, dated July 5, 1996).

¹³³ That choice could not be taken for granted: in Canada each province has one fee schedule; in Australia and France the fee schedules are nationwide.

¹³⁴ Often it is a mix: newer, probationary members of the group practice receive a salary; established members, like partners in a law firm, receive the equivalent of a partnership share of annual revenues.

¹³⁵ Matthew Holt and others, *Medical Ivory Towers and the High Cost of Health Care: A Comparison of Teaching Hospitals in the United States and Japan* (Palo Alto, CA: Asia/Pacific Research Center, Stanford University, 1993) p. 80.

¹³⁶ Spencer Rich, "Cutting Waste: No Cure-all for Health Care," *Washington Post*, May 4, 1993, p. A1.

¹³⁷ For instance, a "carve-out" of cardiac surgery or oncological services, in which a group of hospitals agrees to provide all necessary care of a certain type for some monthly payment per plan member.

¹³⁸ This section of the report is based on my account in *Competing Solutions*, pp. 178-86.

¹³⁹ Although virtually all review systems claim that only physicians can really turn down other physicians, negotiating up to that point is sufficiently time-consuming for the requesting doctor that matters normally do not get so far. In practice much of the process on both sides is performed by clerks or nurses. My own network HMO required frequent renewals of a referral for a chronic condition; I just went to my primary care physician's secretary and the secretary filled out and signed the form.

¹⁴⁰ As David Blumenthal puts it, "for a number of years utilization management/review has seemed to affect physicians' satisfaction more than patients' satisfaction." But that has not entirely been for doctors' want of trying to get their patients angry at the insurers, and as review has become more stringent it has created a backlash due to specific policies or horror stories — especially involving quick discharge from the hospital after giving birth, as is discussed in the next chapter. See Blumenthal, "Effects of Market Reforms on Doctors and Their Patients," *Health Affairs* 15:2 (Summer, 1996) p. 174; the article as a whole gives a good recent account of issues surrounding utilization review and risk-bearing gatekeeper forms of managed care.

¹⁴¹ Rhonda L. Rundle, "Heeding Patients' Mounting Frustration, HMOs Move to Cut Referral Red Tape," *Wall Street Journal*, May 30, 1996, p. B1.

¹⁴² Blumenthal, "Effect of Market Reforms on Doctors," p. 172.

¹⁴³ In a recent forum on health care quality, even defenders of capitation emphasized that it made more sense to capitate a group of providers than individuals; as Alan Zwerner, CEO of the Medical Quality Commission, put it, "it's nuts" to capitate individual doctors. Quoted in Michael Pretzer, "Medicine's Most Elusive Goal," *Medical Economics*, December 9, 1996, p. 166.

¹⁴⁴ A fourth approach is to create a "case manager" for persons with chronic conditions, who would coordinate the efforts of all providers, with some attention to costs. It is not quite a comparable model because it would apply to only a subset of treatments. Also, such coordination need not be oriented towards saving money. If a case manager does face some fiscal limits, she begins to resemble a risk-bearing gatekeeper.

¹⁴⁵ Jon Oberlander, "Managed Care and Medicare Reform," Paper prepared for conference on "Health Care into the Next Century: Markets, States, and Communities," sponsored by the Journal of Health Politics, Policy and Law, Durham, North Carolina, May 3-4, 1996, pp. 3-4. Oberlander is following R.H. Miller and H.S. Luft, "Managed Care Plans: Characteristics, Growth, and Premium Performance," *Annual Review of Public Health* 15 (1994) pp. 437-59.

¹⁴⁶ The obvious example is any sort of profiling of physician practice patterns. That must be both cheaper on average and more accurate if performed on a file of billings for an entire practice, rather than on separate files for each payer's subset of a practice.

¹⁴⁷ See U.S. General Accounting Office, "Canadian Health Insurance: Lessons for the United States," GAO-HRD-91-90 (June, 1991) pp. 64-65; Congressional Budget Office, "H.R. 1200, American Health Security Act of 1993," letter, December 16, 1993, p. 7.

¹⁴⁸ Even then U.S. methods might not be superior. If Canada spent 11% of GDP on health care, of which 1 percent went to administration, and the United States spent 11 percent, of which two percent went for administration, then the United States would only be a better deal if it bought better health care for nine percent of GDP than Canada could buy for ten percent.

¹⁴⁹ On trends see Debra J. Lipson and Jeanne M. De Sa, "Impact of Purchasing Strategies on Local Health Care Systems," *Health Affairs* 15:2 (Summer, 1996) pp. 63-64, 68-69. But see also Robert J. Miller, "Competition in the Health System: Good News and Bad News," in *ibid* pp. 114-15. On effects of market share see James R. Knickman et al, "Tracking Consumers' Reactions To The Changing Health Care System: Early Indicators" *Health Affairs* 15:2 (Summer, 1996) pp. 28-30.

¹⁵⁰ See Miller, *ibid*, pp. 114, 116; Lipson and De Sa, *ibid*, pp. 65-66. A similar story appears to be true for state Medicaid cost increases, which have moderated as much or more in areas where managed care was not relevant as in areas where it was; the data was presented by John Holahan of the Urban Institute at a briefing sponsored by the Kaiser Commission on the Future of Medicaid and the Alliance for Health Reform, Washington, December 3, 1996. In short, whatever has been going on in American health care in the 1995-96 period has involved market behaviors separate from measures to control appropriateness of services.

¹⁵¹ Levit et al, "Health Care Spending in 1994," pp. 133-34.

¹⁵² See Jack Zwanziger and Glenn Melnick, "Can Managed Care Plans Control Health Care Costs?" *Health Affairs* 15:2 (Summer, 1996) pp. 185-99.

¹⁵³ Jonathan Gruber, "The Effect of Price Shopping on Medical Markets: Hospital Responses to PPOs in California." *National Bureau of Economic Research Working Paper* no. 4190. (Cambridge, MA: NBER, 1992; Blumenthal, "Effects of Market Reforms on Doctors and Their Patients," p.180.

¹⁵⁴ For discussions of this issue see the sources cited in Chapter One.

¹⁵⁵ The United Kingdom's version of competition does include the necessary protections against losing necessary capacity. But they are so strong that it would be hard to argue the system is really "competition," and it certainly hasn't saved any money. See the account in White, *Competing Solutions*, chapter 7. The evidence remains overwhelming that, in spite of a massive amount of talk and some action on "outcomes measurement," competition among American plans proceeds almost entirely on the basis of price and cherry-picking or risk-avoidance, rather than on quality. See Miller, "Competition in the Health System."

¹⁵⁶ For instance, governments paid only 13 percent of costs for pharmaceuticals and other medical nondurable goods. But they paid 58 percent of nursing home expenses, and 50 percent of home health care. Levit et al, "Health Care Spending in 1994," p. 139 and author's calculations from Exhibit 8.

¹⁵⁷ Even more strangely, the intensity of admitted cases within DRGs went up, which indicates that hospitals were foregoing those admissions that were less necessary. This is admirable and convenient, but makes no economic sense: the incentive is to seek out admissions whose costs would be lower than the PPS rate. For an account see Joe Feinglass and James J. Holloway, M.D., "The Initial Impact of the Medicare Prospective Payment System on U.S. Health Care: A Review of the Literature," *Medical Care Review* 48:1 (Spring, 1991) pp. 91-115.

¹⁵⁸ The alternatives include managed care plans signing up to provide services on a fee-for-service basis, which does not really count as managed care. Certain plans, usually sponsored by unions or employers, contract to capitate physician services only. And a "Medicare Select" program has experimented with allowing beneficiaries to see providers within a network in exchange for lower premiums on supplemental Medigap insurance. My account here is based largely on Jonathan Oberlander, "Managed Care and Medicare Reform," paper presented at Journal of Health Politics, Policy and Law Spring, 1996 Conference, May 3-4, Durham, NC. On Medicare Select see *BNA's Health Care Policy Report* (June 17, 1996) pp. 1032-33.

¹⁵⁹ Oberlander, "Managed Care and Medicare Reform," pp. 16-19; *BNA's Health Care Policy Report* July 29, 1996, p. 1237.

¹⁶⁰ *Faulkner and Gray's Medicine and Health*, "Perspectives," July 1, 1996.

¹⁶¹ Oberlander, "Managed Care and Medicare Reform," pp. 15-24.

¹⁶² Since Medicare makes few payments to whole specialties, such as pediatricians and obstetricians, its importance to the physicians with whom it does most of its business is greater than its share of total spending would suggest.

¹⁶³ As experienced health policy scholars might expect, surgery was given a separate target because policy actors wanted specifically to reduce funding for surgery relative to primary care. But surgical volume went down much more than anybody expected, which meant fees for surgery actually went up far more than fees for primary care. This could have been interpreted as proof that the system was working; instead, primary care advocates felt surgeons were being favored over primary care physicians.

¹⁶⁴ For both an account of performance and description of the mechanisms, see Physician Payment Review Commission, "Fee Update and Medicare Volume Performance Standards for 1995," May 15, 1994.

¹⁶⁵ Levit et al, "Health Care Spending in 1994," p. 137.

¹⁶⁶ The other logical alternative is to eliminate such a separate lower-class program, making it part of a national health insurance system either on a single-payer basis or in an all-payer arrangement. That of course was proposed in 1993, but did not pass.

¹⁶⁷ Objections to providing service in the emergency room confuse what the hospital bills with the actual marginal cost of the service. If the hospital did not collect those fees, it would try to cover its overhead by raising other fees.

¹⁶⁸ *State Initiatives in Health Care Reform* (Nov/Dec, 1995) p. 6; *State Health Watch*, (May, 1996) p. 7.

¹⁶⁹ Kaiser Commission on the Future of Medicaid, "Chart Pack: Where is Medicaid Spending Headed?" Dec. 3, 1996, figure 10; *State Initiatives in Health Care Reform*, Nov/Dec 1995, pp. 5-8.

¹⁷⁰ William J. Hall and Paul F. Griner, "Cost-Effective Health Care: The Rochester Experience" *Health Affairs* 12:2 (Spring, 1993) pp. 58-69.

¹⁷¹ It may be worth pointing out one of the ironies of traditional American arrangements. At one point the Blue Cross/Blue Shield plans controlled enough of the market in many areas that they could have acted as a market leader that limited capacity. But they had been founded by the hospitals themselves, and were oriented to supporting them. Over time the Blues developed more independence, but by the time they did so, they had less power.

¹⁷² At this point I should say a word about my own biases. I am not much of a believer in comprehensive planning. I am a student of Aaron Wildavsky, who was one of planning's most acerbic (and accurate) critics. But the American way of creating health care capacity makes planning look relatively good.

¹⁷³ See M. Goldberg, T. Marmor, and J. White, "The Relation Between Universal Health Insurance and Cost Control," *New England Journal of Medicine* March 16, 1995, pp. 742-44.

¹⁷⁴ Levit et al, "Health Care Spending in 1994," pp. 134-38. See also Marilyn Moon and Steven Zuckerman, "Are Private Insurers Really Controlling Spending Better than Medicare?" (Washington: The Urban Institute, July 1995).

3.- PROSPECTS AND PROPOSALS IN THE US AND CANADA

The two most expensive health care systems in the world — in countries not coincidentally sharing the world's longest unguarded border, three major sports leagues (baseball, basketball and hockey), a common language (mostly), and cable television stations — not surprisingly face similar fiscal pressures. In each, for the moment, the key policy questions are how costs will be restrained, and with what consequences.

Will these pressures cause the two countries to move in similar directions? One might expect that; indeed, the underlying sociology and technology of health care, as well as the worldwide traffic in ideas of which Canada and the US are only one example, seems to cause similar ideas to be proposed in very dissimilar situations, as shown by the range of "internal market" proposals around the world.

But one might equally guess that the US and Canada, having chosen to differ in this one matter of health care finance perhaps more than in any other aspect of their national lives, will maintain or widen their diversity in that regard.

In this chapter we will look at health reform trends in each nation. As usual there is more to say, though perhaps less to recommend, about the US experience. As usual it also gives more examples of "innovative" ideas than the course of reform in Canada.

But as we talk about reform we are talking about immediate political choices; and as President Clinton could report, one should not be too sure about the political atmosphere even in one's own country, even if you are a master politician.

3.1.- Health Care Reform and Change in the United States

The story of health care reform in the United States is more complicated than in Canada because the US has an extra problem and an extra process. The problem is how to expand (or maybe just preserve) coverage; the process is the dynamic of the marketplace.

We will have to tell the story, then, in five parts. The first is a very abridged version of the failure of efforts from 1993-94 to meaningfully expand coverage, both by President Clinton and a number of states. The second is the failure of the Republican Congress in 1995 and 1996 to enact radical changes in Medicare and Medicaid, so as to balance the budget. Part three is what has been happening in the marketplace for insurance and services — a much harder tale to discern, never mind tell. Part four is the relationship between those market developments and public policy — both how policy encouraged those developments and how policy is now being altered by the need to respond to them. The story ends not with a bang but a

whimper: in part five, we will review the remaining efforts to expand access to health care for Americans.

3.1.1.- *Health Security for All*

President Clinton made passage of legislation to guarantee health insurance to all Americans the most prominent task of his administration. He fought hard for a budget deficit reduction package, declared it essential to the nation, but also declared that health care was more important. He showed health care's priority by making his wife, Hillary Rodham Clinton, the public leader of his administration's effort. That meant he could not renounce the product, nor deflect blame. His commitment was not rewarded but punished: it helped fuel the voter anger that resulted in the Democrats losing control of both houses of Congress for the first time in forty years.¹⁷⁵

It seems fair to say both that the prospects for significantly expanding coverage were never as great as its advocates hoped, and that few if any of the strategies followed by the Clinton administration made it any easier. For the purposes of this report, only the following account seems necessary.

The Clinton administration recognized that the American public had both a great distaste for "the government" as an abstraction and a desire for guaranteed health care. The administration therefore tried to devise a market-oriented version of national health insurance, that would depend largely on private institutions.¹⁷⁶ It was essentially a version of Alain Enthoven's idea of "managed competition."¹⁷⁷

There were a series of flaws in this approach. First, a lot of Americans were less enthusiastic about the idea of "HMOs", private and nongovernmental though they might be, than Enthoven and other policy analysts were. Even though the Clinton plan in fact tried to preserve fee-for-service medicine as an option, it became identified with "managed care" in the public mind because the administration's own rhetoric sought that identification.

Second, under Congress' rules, bills that would increase the deficit could only pass the Senate by an extraordinary majority of sixty votes (out of a hundred). It would be impossible to get sixty votes to increase the deficit. The analysts in the Congressional Budget Office, who were in charge of estimating the budgetary effects of bills, did not believe the available evidence suggested "managed care" could save enough to pay for coverage expansions. In order to get favorable "scoring" of their proposal, the administration's designers therefore had to include stringent "backup" fee controls very much like the international standard. So the true managed care believers, including Enthoven, thought the plan was more like Canada's "single-payer" than like their "centrist" alternative, and opposed it. The Republicans could attack it **both** for being "big government" and forcing people into HMOs!

Third, the administration could not solve the political difficulty of how to get the extra money that was needed. It decided to rely mainly on a mandate that all employers contribute. This was fair and reasonable by international standards — much like the sickness fund systems of Europe and Japan. (Indeed, in all its complexity, the administration's financing was functionally very much like Japan's design in the end). Unfortunately, however, the interests that would have to pay most, mainly small business, were implacably opposed; and in their efforts to pacify small business forces, first the administration and later Congressional Democrats contrived only to lose big business allies (many of whom could have benefited from the details of the plan).

Fourth, in order to operate a system of "competition", the Clinton plan had to propose all sorts of new institutions to keep the competition virtuous rather than vicious. For instance, in order to prevent risk selection and adverse selection, the

administration needed measures both to control plan marketing and to calculate and distribute "risk-adjusted" premiums. In order to subsidize individual purchases of insurance, the administration needed institutions to calculate and then deliver precise subsidies for tens of millions of individuals. In order to ensure that the competition stayed within a budget (so the expansion would not increase the deficit), the administration had to invent not only "backup" fee regulation but a somewhat perverse and nearly incomprehensible set of premium regulations.¹⁷⁸

People who do not like government in the United States generally have three basic objections. They feel government tells them what to do, involves huge bureaucracies, and is an incomprehensible alien force. So the "competitive" Clinton system did not exactly reassure them, but it did confuse the Democratic party base.

Aside from the fact that the political strategy behind the Clinton plan design did not and in all likelihood could not work, the administration also was just plain unlucky. Everything that could go wrong did, ranging from events that divided his party and reduced President Clinton's personal standing, to what would otherwise be good news, such as an improving economy, that somewhat relieved public anxiety about health care security. For our purposes, however, the basic lessons should be based on policy. First, leaders who seek to expand their nations' health care coverage could not, based on the Clinton experience, take any comfort from the idea that "managed competition" offers savings that can be used to pay for that. Second, all the talk about reform of the health care system is irrelevant if you cannot find someone to make pay for the expansion.

No one should imagine, however, that the Clinton effort was therefore some sort of obviously unpopular aberration. At the beginning of 1993, and even in 1991 and 1992, there was a ferment of proposals and even action at the state level. Vermont, Washington, Oregon and Minnesota all seemed plausible candidates to create universal health insurance in their own states. Their momentum may have been drained somewhat by concern that national action might make their own unnecessary. But the main problem in the states was that leaders of the effort to create universal coverage in those states ran into the same obstacles — inability to find the money and agree on a form of cost control — that blocked action at the federal level. They were further constrained by existing federal laws that limited their flexibility to design cross-subsidies and manage their systems as a whole. These included especially the difficulty of coordinating with Medicare and Medicaid, and the provisions of the Employee Retirement Income Security Act that forbade state regulation of self-insured health plans. It appears that in the United States, federalism encourages innovation so long as it is fairly small.

As a result of the Clinton administration's failure, the United States did not enact any form of managed competition. Developments in the marketplace, however, would yield to a proliferation of restrictive selective contracting arrangements — in essence, unmanaged competition.

3.1.2.- *Medicare, Medicaid and Balancing the Budget*

The 1994 election was one of the most decisive political reverses for a governing party in American history. The Democrats not only lost control of the legislature, but also were swept out of the governor's office in many states. By 1995 Republicans dominated the nation's governorships and even had the edge in state legislatures. The new majority quickly began to overturn the most extensive coverage expansions at the state level, while moving to more ambitious tasks on the national scene.

Essentially, congressional Republicans were committed to both balancing the budget in the year 2002 and providing a tax cut to voters as well. That tax cut was fairly small compared to the federal budget (\$281 billion over seven years, in a budget that would spend about thirteen trillion dollars).¹⁷⁹ But it was large enough that any program could be cut less if the tax cut were eliminated.

Budgetary and political arithmetic seemed to compel the Republicans to attack Medicare and Medicaid. They wanted to protect the military; could not touch interest on the debt; and did not dare be seen touching the main pension program, social security. In fiscal year 1995 those three categories alone accounted for 54 percent of the budget. With them off the table it was hard to avoid cutting Medicare and Medicaid, which in 1995 were 17 percent of the budget and were projected, by 2002, to rise to 24 percent. In fact, the entire projected deficit in 2002 was due to the projected growth of those two programs.¹⁸⁰ Besides, many Republican members of the House and Senate did not much like Medicare and Medicaid anyway. In the Budget Resolution that Congress passed in the Summer of 1995, Medicare was targeted to be cut by \$270 billion from projected spending by 2002, and Medicaid by \$182 billion.¹⁸¹

A budget resolution, however, is not specific. It was easier to vote for an amount of cuts and claim it could be done painlessly than to write the law to do so and make the same claim. A budget resolution also is only a rule for Congress' internal proceedings. It does not require the President's approval. Laws do, and Congress needs a two-thirds majority in each house to override a presidential veto. The Republicans did not have close to a two-thirds majority.

In order to overcome the President, the Republicans had to hope that the public would be more interested in a balanced budget than in protecting Medicare and Medicaid. Medicare was known to be extremely popular with the public. Medicaid's popularity was less certain, but one could think of reasons that it might be hard to cut. Health care for women and children was harder to stigmatize than "welfare" cash payments. Many Americans either were elderly or had elderly parents who might need Medicaid's nursing home benefits.

Unfortunately for the Republicans, they were on the wrong side of the public debate. Nevertheless, their tactics may be instructive.

If you want to make an unpopular spending cut, the most obvious tactic is to hide the details as long as possible and then try to rush it through. That limits informed criticism at the time and gives your party's members the excuse that they had to vote, yes or no, in order to pass legislation on time. The Republicans did this with their Medicare legislation, and it probably helped.

It would also be nice if you could maintain you are "cutting the program in order to save it." That argument is especially compelling if a program has separate financing and the fund is losing or threatened by loss of money. Thus, just as in Germany and Japan cost controls are justified by the financial condition of sickness funds, Republican leaders argued that Medicare had to be cut to "save" the Hospital Trust Fund (HI). A report by that fund's trustees in the Spring of 1995 helped the cause of spending cuts because it reported that the fund had begun to take in less than it spent, and would be "broke" by 2002.

The impending bankruptcy of the HI fund was true (as far as anyone could tell), but not quite what it seemed. If one were really worried only about the HI fund, one would not propose changes that affected SMI. Yet the Republicans did just that (which was defensible policy if the subject were Medicare, but not a way to "save" HI). As mentioned in chapter 1, the rise of services like Home Health make the separate HI fund a rather outdated device anyway. Moreover, the fund's trustees had

reported impending bankruptcy frequently in the past, and Congress and the President had responded with incremental changes, rather than as radical a reform as the Republicans tried to legislate. Nevertheless, the issue of saving the HI fund helped put the administration on the defensive.

If you are going to propose cuts, it is wise to make them as vague as possible. Ideally, somebody else should be forced to fill in the details. The usual suspects are lower levels of government and, "the market."

For Medicaid, the Republicans promised both. The program would be turned into a "block grant": money would be given to the states to provide coverage, according to a formula that directly reduced projected federal spending. In theory, the states could maintain services by relying on "managed care" to make everything more efficient. However, the block grants projected to a 26 percent spending cut in 2002.¹⁸² That was a lot to expect from managed care, since the observed savings to date have been more like five to fifteen percent, and that only in the thirty percent of Medicaid funds that serve mothers and children. Thus the overall observed savings are more like 1.5 to 4.5 percent.¹⁸³ How managed care was going to save money in nursing homes was never quite explained. Nevertheless, the block grant mechanism ensured that these would be real cuts, at least from the federal perspective. Its basic policy was a very large change: instead of the federal government guaranteeing that beneficiaries would be entitled to care, the federal government would make a promise but it would be much vaguer and whether it was enforced would be up to the states.

For Medicare, the Republicans relied on "competition" and "choice." Medicare beneficiaries would have the option of staying in the basic Medicare plan or, instead, taking a voucher with which they would shop for insurance. The theoretical argument for vouchers is, people will join managed care plans that save money.¹⁸⁴ Unfortunately for the Republicans, that has all the same difficulties for Medicare reform as it had for the Clinton plan: CBO did not believe it would save that much (if any) money, based on Medicare's own experience, and public distrust of being forced into managed care was still high.

The Republicans responded with measures that were fairly stunning in their defiance of policy sense. Their vouchers would have been usable for any form of coverage: not just managed care but indemnity plans and even plans with very high deductibles ("catastrophic" coverage). In the latter case the insurance would cost less than the voucher and beneficiaries could put the balance in a "medical savings account" (MSA). Congressional Republicans promised that traditional fee-for-service Medicare would remain available for those who wanted it, though subject to the same budget caps as the vouchers. This design, however, exacerbated the chances of risk selection by insurers. There would be more plans competing for business; many would be smaller; many would have no way to control costs other than by risk selection, since they did not manage care. At the same time, the MSA-option seemed particularly prone to favorable selection, because it offered extra cash to healthy people.¹⁸⁵

As biased selection increased, how would costs in the traditional Medicare be controlled? By backup fee regulations, just as in existing Medicare and in the Clinton plan. Again, CBO had to have a mechanism its analysts could believe. Again, the available data did not support claims for large savings from selective contracting. But the consequences of the Republicans' backup savings plan within the likely biased selection of the voucher proposal were particularly perverse. As sicker people were concentrated in the residual unvouchered plan, but held to the same financial targets as the healthier people in the voucher plans, the "backup" fee controls would have to

be especially severe — in essence realizing much larger cuts, for that population, than the cuts to Medicare overall.

Or so it seemed likely. In the event, President Clinton felt compelled by budget politics to propose his own "budget balance" plan. His savings in Medicare and Medicaid, however, were much less than theirs,¹⁸⁶ and he relied entirely on traditional methods, without either eliminating the entitlement for Medicaid or voucherizing Medicare. He also had no trouble maintaining popular support for his veto.

One hesitates to draw lessons from a debate of this character, but a few may be hazarded. The Republicans came quite close to enacting radical and unpopular reforms, so their tactics might deserve consideration even though their plan was fairly short on analytic justification. There is little evidence that the public understood the risk adjustment issue. Instead, they simply distrusted the Republicans on Medicare. The proposed cuts seemed very large — and suspiciously similar to what was needed to pay for the tax cut.

In fact, nobody really knows how severe either side's "cuts" were. In all cases they were reductions from a projected rate of increase. The same targets would create smaller "savings" if the underlying spending "baseline" were lower. Whether CBO's projected rate of increase was reasonable depended on things that could not be known, such as trends in utilization of services and levels of fees paid by private insurance. If fewer people than expected entered nursing homes, or states found new ways to control those costs, federal Medicaid costs would fall, so lower targets would be less of a threat to services. Similarly, if private payers managed to freeze physician fees, then Medicare could do the same without much chance that would reduce doctors' willingness to serve the elderly.

The real substantive issues, then, were not so much the spending targets as the program design changes. Eliminating the entitlement to Medicaid would have been a huge change. So would creating vouchers with no significant risk adjustment for Medicare. Without the President's veto, they would have happened. At the time of this conference we will know whether the Republicans both won the presidency and maintained control of the Congress in the 1996 elections. If so, the federal health care programs could be seriously damaged.

3.1.3.- *The Health Care Marketplace*

Whatever the federal government may do, American health care arrangements seem to have entered a period of great turbulence. It is characterized by ever-more Americans receiving their care through some sort of selective contracting arrangement; providers therefore maneuvering to improve the odds that they will be selected on favorable terms; and insurers and other third-party payers seeking to combine patients and physicians on terms that are most profitable for the third-party payer.

The most obvious symptom of this trend is the continual news of mergers among providers and insurers, as they struggle to increase their market power. Headlines suggest the story: "Aetna, US Healthcare Announce \$8.9 Billion Merger Agreement";¹⁸⁷ "A.A.R.P. Will License Its Name to Managed Health Care Plans,"¹⁸⁸ "Community Health Accepts Bid of \$1.1 Billion From Forstmann";¹⁸⁹ "Ohio Blue Deal Raises Question of Who Gets the Green."¹⁹⁰ In this profit-driven competition, the need for capital to gain market share seems paramount. The Blue Cross/Blue Shield system of nonprofit insurers, still the largest source of health insurance outside the federal government, is losing its nonprofit identity as local plans start for-profit units, emphasize restricted networks, and merge with for-profit insurers.¹⁹¹

Based on a Robert Wood Johnson Foundation project that gathered dozens of researchers to study trends in fifteen health care markets, Paul B. Ginsburg provides a useful interpretation and summary of the trend:

"Providers that have always competed for individual patients on the basis of individual reputations and relationships with other providers now are competing for blocs of patients on the basis of price and organizational reputation. In response to this, health care markets are consolidating at a rapid pace. Hospitals are consolidating most rapidly, and physicians least rapidly."

But the process of consolidation works differently in different markets:

"The capabilities of existing organizations are a key factor in the differences. When a segment of the health care system has organizations that are large, well-managed, and well-capitalized, that segment is likely to play an important role in change—in terms not only of the market power that comes from size or consolidation, but also of existing organizations' ability to shape how care is delivered."

The reason is,

"In the production and delivery of most goods and services, one organization tends to arrange for design and production and to market the product. Under the traditional health care system, this general contractor role tended not to exist as patients went to physicians and other independent providers, and insurers passively paid the bill. Today, health plans most commonly assume the general contractor function. Providers in some communities, with purchasers' encouragement, are attempting to take over this general contractor role from health plans."¹⁹²

In Canada this "general contractor" role has been taken by the provincial governments. In other countries, we may say it is shared by the government or sickness funds with peak organizations of providers, although the government tends to have the upper hand. In the United States various players are competing for the advantages of the role; yet most of them have little interest in some responsibilities that might go with it, such as maintaining availability of the system to all citizens.

Whether this market turbulence is having any net negative effects on people who have insurance remains at best unproven. To begin, we have to realize that consolidation at the peak of organizations is not the same as consolidation of services — just as mergers of sickness funds with private insurers in the Netherlands has not created "managed competition." Ginsburg reports that the merger movement at the hospital level is not yet matched by closures of duplicative capacity.¹⁹³ Consolidation in many cases seems to have a life of its own as a management fad, rather than as a specific response to local conditions. As another of the Robert Wood Johnson reports put it, in some markets, "some hospital mergers appear to be a hasty reaction to intense fears rather than to the actual pressures of purchasers or insurers."¹⁹⁴ Under those circumstances, once a merger agreement is made, consolidations at most should proceed slowly.

Beneficiaries' choices among plans and physicians are being reduced. Employee contributions towards the cost of premiums are rising. But, as discussed in chapter one, the spread of managed care does lead to lower costsharing within plans. Individuals and families who are forced by their employers to change health care plans and providers go through unpleasant dislocations.¹⁹⁵ Hospitals are, indeed striving to reduce their costs. In 1995 the number of staffed beds in acute-care hospitals fell by 1.8 percent, but the number of days in hospital fell by 2.9 percent, as hospitals reduced lengths of stay. Cost per case grew at the slowest rate ever, 1.8 percent.¹⁹⁶ As hospitals strive to cut costs, accusations fly that they are reducing services to a dangerous extent.¹⁹⁷ But, if that is occurring, it is simply too early in the process for

bad effects to be documented in any convincing manner. Costs may be reduced not by declining levels of service, but by greater efficiency in the hospitals or even lower incomes for providers. There is some evidence for those effects, the strongest piece being that in 1994, for the first time ever, physicians' incomes, as reported by the American Medical Association's survey data, fell.¹⁹⁸

As of the Summer of 1996, the limited evidence available also suggested that the new dynamics in the marketplace were continuing to restrain at least employer health costs. In one survey, companies with fewer than 1,000 employees saw their expenses rise by only 1.6 percent between 1994 and 1995. The authors reported that the savings seemed to be associated both with switching from indemnity plans to restricted networks, and with HMOs cutting their rates in the face of stiffer competition.¹⁹⁹ A Labor Department report was even more optimistic, saying employer health costs had risen only 0.1 percent in the fiscal year ending June 30, 1996. Whether that was because of a reduction in coverage, or one-time savings from shifting to managed plans from less managed ones, or reduction of adverse selection by limiting employees' choice of plans, or any other factor, was simply unanswerable from the data available.²⁰⁰ A major buying group in California announced agreement with HMOs to keep premiums flat in 1997. Yet that was after a 4.3% premium decrease in 1996, and one had to wonder whether it was getting harder for the market to squeeze capacity out of the system. The profits of one major HMO plunged in the second quarter of 1996 due to higher medical costs, spurring a sell-off of health insurer stocks.²⁰¹

It seems reasonable to assume that a change in market dynamics that began in 1993 continued into 1996. This heightened competition, stronger in some regions than in others, was able to achieve some real savings by reducing incomes of providers and squeezing out some excess capacity. Perhaps, however, it was becoming harder for providers to live with the lower payments, and they were beginning to resist reductions more strenuously. Just as in any health care system in which a government or coalition of sickness funds played the role of general contractor, the consequences for care from harder bargaining by the payer(s) could not be judged immediately. Just as in that situation, there had to be a point where the people who really managed care — physicians and hospital managers — would in fact start providing fewer necessary services than before.

In spite of the publicity given to plan-level treatment protocols and rules, the growing reliance in the US on gatekeeper arrangements and hospital discounts meant that care was mainly being managed by hospital staffs and managers and by ambulatory care practice physicians. But unlike in Canada, hospitals and physicians could reduce their care for the uninsured in order to save money. Competing third-party payers could reduce their contracting with those providers that provided the most care to the uninsured. The dynamic of the market might drive out overcapacity, but if it did, would it be the right capacity?

Managed care scholar Harold Luft has argued that the advantage of the American version of competition is that it might force consolidation of a badly overbuilt system far more quickly than governments could manage under all but the most unusual circumstances.²⁰² Analyzing recent events, he concludes that the US is now seeing the expected "squeeze on prices, a squeeze on profits, and consolidation among providers." Yet, he adds, "It is very clear that competitive systems do not take care of people who don't have dollars to vote. And we can anticipate reasonably well that safety net providers will be squeezed out of the system." He asks, therefore, "Who will take the responsibility for taking care of those people? And who will take

responsibility for providing services in the areas in which those people live if those providers close?"

Luft is optimistic. He suggests that, "what competition might be able to do is downsize the system enough so that it then becomes politically feasible to say we will now cover the uninsured," since it would be cheaper. And he hopes providers, desperate for new markets, will support that effort.²⁰³

Yet most estimates project the rate of uninsurance will only grow — to as high as 50 or 55 million people (on the same basis as discussed in Chapter One), by 2002. Cutting health care costs has become a basic goal among business managers, driven no longer by desperation about costs that seemed out of control, but instead by competition to lower costs as much as any rival or to gain an advantage. Therefore, employers are seeking to cut their health care costs, "whether the organization is experiencing losses or earning record profits."²⁰⁴ A smaller share of the workforce is expected to have the full-time, higher-paying jobs that are most likely to offer insurance benefits.²⁰⁵ So expanding health insurance will require that a smaller proportion of insured people assist a larger group of uninsured. All the interest groups that opposed taxes or employer mandates before are as likely to be opposed in the future. Moreover, to the extent consolidation occurs on the supply side, that would restore the balance of market power and the incomes of providers. Already, it is clear that payers have much less influence where providers have more of a monopoly or oligopoly position.

Professor Luft's hope is a longshot. It requires that capacity be reduced enough to substantially cut costs, yet enough excess still exist to force the medical profession to swing its weight behind expanded coverage. The people who have insurance must suddenly become much more generous to those who do not. It seems more reasonable to hope that the move to managed care saves enough money to stem the decline of insurance coverage. Even that may be optimistic.

3.1.4.- *Market and the State(s)*

The developments in the American health care marketplace have not occurred within a policy vacuum — though policy may mainly have affected them in unintended ways.

At the most fundamental level, participants in the health care marketplace widely report that first the Clinton plan and then the Republican Medicare proposals gave a strong impulse to their interest in reorganizing to strengthen their competitive positions in a world of managed care. This encouragement from the political arena was only enhanced in states, like Oregon, Washington and Florida, that were considering their own versions of "managed competition" reform.²⁰⁶ This reaction in anticipation of something that did not happen nevertheless took on its own momentum, as participants in the market responded to each others' moves.

The growth of managed care as a force in the health care marketplace was encouraged even more directly by the policies that expanded its role in Medicaid. Even without legislation, the federal government participated by providing states with waivers of underlying Medicaid law. The most significant of these waivers involved arrangements through which states promised to expand coverage using the same amount of federal spending as would have occurred in traditional fee-for-service Medicaid, if the federal government, in turn, allowed them to save per capita with some form of managed care (and, in the case of Oregon, more innovative measures). Federal policy then became particularly important because the likely federal contribution under the old arrangements had to be estimated. Within the budgeting

community it was widely believed that the President's Office of Management and Budget, in order to encourage coverage expansions, projected future spending in those states at a higher level than was likely, thus providing a new, unlegislated subsidy for those expansions.²⁰⁷

Because the proliferation of managed care within state Medicaid plans involved a series of state policies and uncoordinated federal waivers, these plans differed on many dimensions. Some states assigned beneficiaries to plans; some allowed them to choose plans; and some did it one way in some counties and the other in other counties.²⁰⁸ Vermont had trouble even finding a managed care organization that could meet the state's criteria for its Medicaid business, while, in California's Orange County, major established HMOs limited their involvement.²⁰⁹ Some states sought to combine state employees and Medicaid beneficiaries in a single purchasing pool so as to increase the pool's bargaining power — though state employees tended to deeply dislike that idea.²¹⁰

States' versions of Medicaid managed care also have varied in much more fundamental ways, due to both particular leadership and local political conditions and opportunities. Tennessee created perhaps the most significant coverage expansion in its "TennCare" plan. Blue Cross/Blue Shield, the major nongovernmental insurer in the state, gave "TennCare" a huge boost by declaring that physicians who wanted to participate in its own preferred provider network also had to take TennCare patients. In spite of a great deal of stress, TennCare has survived.²¹¹

Ohio, by way of contrast, did little or nothing to expand coverage. It did have significant achievements in cost control, while moving parts of the Medicaid population into managed care. Yet its most significant achievement, and savings, may well have been based on something much more like traditional Medicare cost controls: creation of a form of prospective payment for nursing homes.²¹²

Oregon created a unique approach, in which eligibility was expanded but the covered benefits were defined more strictly. In essence the state created categories of treatment and condition (thus, "condition-treatment pairs"); rank-ordered them; and then promised to fund more patients by dropping the less important condition-treatment pairs. This explicit and seemingly rational tradeoff appealed to analytic notions of efficiency because it funded more individuals by eliminating only "low priority" treatments. The "Oregon plan" therefore received a great deal of international attention.²¹³ In its own terms it appears to have been successful by expanding the number of Oregonians with insurance. Yet the evidence suggests that the reduction in treatments covered was more a short-term political tradeoff than a new model of cost control. When faced with a budget shortfall in 1996, Oregon's political leaders chose not to follow the supposed logic of the Oregon plan: reducing the covered services by moving up the priority list.²¹⁴

Whatever their effects might have been on states' Medicaid populations, states' encouragement of managed care, added to the dynamics within the private market, increased the vulnerability of uninsured populations and the providers who served them. This in turn put pressure on separate state programs to support those providers, such as New York's rate-setting and Massachusetts' indigent-care pool. In essence, methods that forced suburban hospitals to subsidize urban centers needed even more funds when managed care further increased the urban hospitals' needs. Yet the general cost pressures, ideological swing against rate regulation and tight state budget situations combined to make the subsidies even less sustainable. Reliable solutions to this problem were hard to find and, given the regularities of the budget process, it tended to recur from year to year.²¹⁵

Policy choices related to managed care, however, are hardly limited to controversies about the poor and the uninsured. Managed care, by definition, involves

contradicting the judgment of some professionals and the desires of some patients. This interference with medical treatment for the well-insured is relatively new, and while managed care was truly a voluntary choice, perhaps a lack of regulation might have been easy to justify. As more and more people are forced to accept its constraints, however, the rules and regulations of managed care have become a more significant political issue.²¹⁶

Physicians have raised objections for many years. Their preferred reforms have been "any willing provider" laws that, in essence, would eliminate plans' ability to engage in selective contracting. The AMA does not ask that plans be forced to contract with any physician who is willing to meet the plans' terms. It does, however, say that refusals or terminations should be based on objective criteria, and physicians should have an appeals process.

That formalization of plans' criteria, alone, would be a major burden to plan administrators. It would raise the costs of maintaining their networks; force them to be explicit about criteria about which they might not want to admit much; and reduce an element of arbitrary discretion that should make physicians (like anyone else in a similar situation) less likely to protest plan decisions. The managed care industry, therefore, has fought "Any Willing Provider" laws at all levels. It has stopped all action at the federal level, but has had to accept mild compromises in a number of states.

As of 1996, the plans were giving ground on two other kinds of issues. One involved "gag rules": rules that restricted network providers' communications with patients. Doctors might be punished, for instance, for disclosing treatment options that the plan would not fund, or explaining the plan's review process, or advocating on behalf of the enrollees. By mid-1996 18 states had passed laws that in some way restricted gag rules. Within Congress, the American Medical Association and the American Association of Health Plans compromised, and a House of Representatives subcommittee reported a "Patient Right to Know Act" that banned plans from writing contract clauses that limited what physicians could say about treatment options, but did allow clauses forbidding them to criticize plans or disclose financial incentives for reduced care.²¹⁷ As 1996 came to an end, individual managed care companies announced that they were revoking all "gag rules," and the American Association of Health Plans sought to head off legislation by announcing voluntary standards for all its members, under which members would refrain from the most controversial kinds of contract clauses, and would provide patients with information on issues such as how the plan decides which services or treatments will be covered.²¹⁸

The second set of issues involved specific utilization standards. A series of examples dramatized patients' dissatisfaction with managed care. For instance, in their drive to save money by limiting hospital care, managed care companies had steadily reduced allowable hospital stays for delivery. This followed a professionally-accepted change in the norms for treatment. The American College of Obstetricians and Gynecologists' recommendation that mothers normally remain in hospital for 48 hours after a vaginal delivery and 96 hours after a cesarean section was much shorter than the norm in previous decades. But managed care plans pushed for more. By 1994, the average length of stay for a normal delivery in Ohio was down to 42 hours, and an estimated 18 percent of newborns and mothers were being discharged from the hospital within 24 hours. This was not a great idea medically — some blood screenings for the infant are not valid if done before he or she is 48 hours old.²¹⁹ And it made many mothers quite dissatisfied, since women who have given birth in the past 24 hours tend to be very tired. Some want to go home, but many would prefer to rest for another day in the hospital and have the hospital nurses take care of the baby.

Many states, therefore, were passing legislation that promised to make length of stay an attending physician's decision. Whether physicians could truly be protected from retaliation for keeping maternity patients and newborns in the hospital "too long" is hard to say. A plan that was forbidden (as in Ohio) from retaliating against physicians solely on these grounds might find some other grounds. But at least the laws created legal uncertainty for the plans, and they definitely responded to public pressure. The pressure was so clear that support for these bills tended to be bipartisan and nearly unanimous.²²⁰ At the end of the 104th Congress in September, legislation against "drive-through deliveries" was enacted at the national level. As one insurance industry official admitted, the industry was on the wrong side of "the mother of all motherhood issues."²²¹

In another example, a few HMOs began trying to set a standard that mastectomies be performed on an outpatient basis. This too presented a fine target for advocates of regulation of the managed care industry, and within weeks of the issue beginning to receive publicity, the American Association of Health Plans was trying to head off legislation by declaring that their members "do not and should not require outpatient care for removal of a breast." Whether that statement would head off legislation in the Congress that would take office at the beginning of 1997 remained to be seen.²²²

Another common complaint against managed care American-style involves visits to the emergency room. The difficulty is, sometimes a person has symptoms that might be something very serious (e.g. a heart attack) or something unthreatening (e.g. indigestion). If he went to the emergency room at the hospital, and the condition was determined to be unthreatening, insurers might refuse to pay, on the grounds that the service was provided out-of-network and was not, in fact, an emergency! In response to this concern, Kaiser-Permanente, the largest HMO, and the American College of Emergency Physicians agreed on legislation that would require insurers to pay for emergency room visits if a "prudent layperson" would have reason to be fearful. But the fate of that legislation also remains to be seen.²²³

What all these cases have in common is, they provide illustrations of care "management" that are very hard to defend, from any ideological perspective. As a result, some of the strongest legislation to protect consumers from mismanaged care has been endorsed by Republican politicians. In New York, Republican Governor George Pataki offered a plan that required plans to "release detailed information about their policies, including the drugs they will pay for, the guidelines they use to reject claims, and their criteria for selecting doctors." Further, it "would allow people who mistakenly go to emergency rooms, thinking they are gravely ill, to be reimbursed, even if their problems are not life threatening." Democrats took credit for pressuring the governor into responding.²²⁴ Yet the fact that he did, and that other Republicans were responding similarly across the country, indicated that public concerns were extremely clear to the people who have the best incentives to judge: politicians.

This public backlash against managed care, and call for the State (or at least the states) to regulate the market, clearly is deeply rooted and should be expected to continue. The need for a substantial regulatory structure was a major part of the original argument for managed competition.²²⁵ Yet it would be a surprise if the backlash created a comprehensive and effective regulatory structure.

It would be surprising, first, because the measures adopted so far remain exceptional or weak. They respond to horror stories that can be avoided by a little more political sensitivity on the part of health plans. There are few cases analogous to pregnancy that involve restrictions that a very large part of the population can expect

to affect their lives, and anyone can understand (or think he understands). Requirements that plans disclose their procedures are unlikely to have much effect, because the odds that the average patient would read such documents must be quite low. Indeed, as in most disclosure requirements, it can be vitiated by providing an intimidating amount of "information." Even if used, this information only would help people choose among plans in the marketplace, and few may have that choice. There has been much less support for strong measures like giving physicians or patients actionable rights in court.

Moreover, in a fast-evolving environment, it will be difficult for regulators to invent and convince the public to accept regulations with speed comparable to plans' innovations in contracting. It may be possible to regulate competing health plans, but only within a comprehensive structure with a wide range of sanctions. If plans had to be licensed at regular intervals in order to sell their products, or were paid from a central fund rather than marketing directly to customers, the agency that controlled the licenses or fund would have much more power to affect plans' behavior than can exist in any system of unconnected laws, enforced through varied means.

There has been hardly any support, as well, for crucial controls such as risk adjustment, or limits on deceptive marketing, or any but voluntary compliance with outcome or quality measures. Some of these goals are more substantively practical than others, but all were included in the original managed competition proposals, for good policy reasons.

We may expect, then, that states and the federal government will continue to build regulatory structures in a piecemeal manner, responding to horror stories and public pressure. At some point difficulties caused by state-to-state variation may cause the managed care industry to support comprehensive national regulation that preempts state authority. The politics of that regulation will become ever more complicated, and the threat of further action may cause plan managers to be cautious about the measures they implement. Yet there is little prospect that the backlash will lead to enactment of the kind of "management" of competition that was planned in the original proposals by Alain Enthoven and his colleagues.

3.1.5.- *Incremental Coverage Expansions*

The Republican victory in the 1994 elections took major coverage expansions off the political agenda at both federal and state levels. Nevertheless, minor efforts to make health care coverage wider have continued, with some minor results.

The most significant efforts occurred in states that invested in new insurance subsidies. Much of the money involved came from federal Medicaid funds; other funds come from charges to the beneficiaries and some state revenue. The fifteen states with significant programs covered about one million extra people in 1996. About a third of those are in one state, Tennessee; Washington, Minnesota, and Oregon account for another third.²²⁶

Most of the state efforts, however, involved incremental reforms to the process of buying and selling health insurance. Throughout the early 1990s, for instance, states had adopted various measures to create "buying pools" that could (in theory) help small businesses overcome the higher marketing charges associated with their size, so make insurance more affordable to them. Another approach involved making exceptions for small purchasers to state laws that required certain benefits be included in insurance packages; by allowing less generous plans, it was argued, insurance would be made more affordable. 35 states adopted measures, mainly weak ones, that in some manner required that some insurers guarantee issue of insurance to applicants. 41 states passed

legislation to make it easier for people who left an insurance plan because they lost a job or changed jobs to qualify for insurance in a new job or by private purchase. That was a major concern because people with preexisting conditions were finding that, if they left one plan, another would not accept them or would not cover that condition.²²⁷

These latter reforms, though widespread, did little to expand coverage. The main problems were that they did little to make coverage more affordable, and that employers who were not contributing to health insurance generally had little interest in doing so. In a competitive market, after all, why would anyone take on an extra cost if they did not have to? Guaranteed issue sounds nice, but if insurers can charge whatever they wish to high-risk customers, they can raise prices high enough so that very few purchase the coverage. Without significant rate regulation, guaranteed issue would accomplish little.²²⁸ Some of the small business pools did succeed in offering lower rates, but their membership remained quite limited.²²⁹

Some states did try to make insurance more affordable for more risky populations by legislating a version of community rating. Only New Jersey created true community rating, requiring that rates for the individual market be set without regard to applicants' age, gender, health status, occupation, or residence.²³⁰ Other states tended to allow limits on variation within age, gender and geographic area groupings, and some limit on variation among those categories. In general these reforms made insurance more affordable for less healthy people. But the reforms did so by raising rates for healthier people, who tended to protest (and there are more of them). Insurance companies fanned the protests. As should be expected whenever the rules change, some participants misjudged the rules. These insurers ended up raising their premiums substantially, and blamed the system. Kentucky's community rating program therefore was revised in 1996 to allow up to a fivefold difference in rates among age categories, occupational differences of 15 percent, and gender differences of fifty percent.²³¹ At best, it seems, momentum to create community rating had stalled.

At the national level, however, there was progress on the issue of "portability". After a very complicated battle, in August of 1996 Congress passed and the President signed the Kassebaum-Kennedy bill. As the major product of four years of controversy about expanding American health insurance, Kennedy-Kassebaum deserves some attention. Yet that discussion may mainly convince readers that American policymakers deal with a lot of complexity while not accomplishing very much.

The bill's main purpose was to assure that if a person had health insurance and had to give it up due to a change of employment, he or she would be able to gain coverage from a different plan.²³² The new law still allows both individual and group insurance plans to exclude coverage of preexisting conditions for up to 12 months. But a person who has been insured for a period preceding application to a plan can deduct a month from that exclusion for each month of previous insurance.²³³ Also, pregnancy and newborns are covered right away. Thus a person who is insured for a year and then changes employers cannot have a condition excluded from that new employment's insurance coverage. Modest as that might seem, it is a significant improvement for anyone with a chronic condition.

A person who has insurance through a job and loses it without moving to a job that provides different coverage already is entitled to keep that job's insurance for 18 months by paying premiums under the federal COBRA program. After COBRA coverage expires, they are guaranteed the ability to buy an individual insurance policy. Insurers are required to offer a choice among all their policies, a choice between their two most popular policies, or a choice among two new policies, one with high and one with low coverage. They are not allowed to discriminate on the basis of health status in the

rates for these policies. How well this provision would work was less than clear. Insurers might offer relatively undesirable packages. Moreover, the law provided that these individual coverage arrangements "for the most part... would defer to state laws that guarantee health care for individuals through risk pools, mandatory group conversion policies, open enrollment, or other means. The federal rules would kick in only if states have no acceptable laws or do not pass them in the future, and Republicans argue that only about six states currently would fit in that category."²³⁴ What constituted an acceptable law, however, apparently would be decided by the Secretary of HHS or the courts, so the bill's effect remained to be seen. In spite of the uncertainties, the bill's provision could only improve on the status quo.

The bill did little, however, to make health care more available to the existing uninsured. It would raise the health insurance deduction for the self-employed from 30 percent to 80 percent over ten years, and included a scattering of other new tax breaks for long-term care.²³⁵ The bill's major provision to supposedly expand coverage was in fact extremely controversial: tax breaks for medical savings accounts.

It may be appropriate to end this discussion of American reform prospects with medical savings accounts. The idea may have resonance in some parts of Latin America, for it certainly fits the privatization of social security. Medical Savings Accounts also symbolize the peculiar character of American health care policy among the wealthy industrial democracies.²³⁶

The basic idea of medical savings accounts (MSAs) is that health care will be less costly if people buy less of it. They are believed to buy too much because, in using insurance, they do not have to spend their own money, so do not have to worry about the cost. They are believed to have more insurance than they should because the federal government subsidizes health insurance through favorable tax treatment.

MSA advocates more or less recognize that insurance is necessary for some health costs. But they feel it should cover only costs above a substantial deductible — in the final version of the Kassebaum-Kennedy bill, at least \$1,500 for an individual and \$3,000 for families. In order to help people pay for costs below this level, MSA advocates say the federal government should provide tax breaks for savings accounts, from which withdrawals could be made without penalty for medical expenses. Their notion is that people would rather have savings than contribute to insurance plans, and in turn would rather maintain savings than spend on health care.

To what extent any of this analysis is true is a matter of substantial doubt. Clearly price constraints matter; just as clearly, MSA advocates in the United States grotesquely overstate the evidence in support of their position. Neutral analysts tend to conclude that the possible savings from MSAs are around 5 to 10 percent of spending, compared to the average fee-for-service plan; less or zero compared to the more effective versions of managed care. All these estimates are based on evidence in which plans with high costsharing are a very small part of the health care market, so providers do not seek ways to game the system and raise costs; if MSAs were the dominant form of coverage, the savings might well be smaller.

In fact, however, nobody knows what MSA-based reforms would do, because it is impossible to predict how widely MSAs would be chosen in a voluntary system. For fairly obvious reasons, they should be much more attractive to healthy people. As healthier people chose MSAs, rates for the remaining comprehensive insurance would rise. Then more people might join the MSAs, raising rates further and creating a "death spiral" that destroyed comprehensive insurance, leaving a world in which sicker people each year paid substantial sums out of pocket to cover their deductibles. But in a world in which employers pay for much of the health insurance bill, employers might not let that

happen. An employer who was required to offer employees a choice between MSA-based and other insurance would have to worry that adverse selection would mean she was handing extra cash to some employees, and would have higher expenses to others. She therefore might try to set the MSA contribution quite low, and might even set it so low that few employees joined. For this and other reasons, estimates of potential membership in MSA plans have varied greatly, and one cannot predict spending effects without knowing who will join the plans.

Whatever the participation, no authoritative analyst believes the savings from MSAs could compensate for the biased selection inherent in having an MSA option. Therefore Congressional Budget Office estimates have continually said tax breaks for MSAs would cost money. The risk is overwhelmingly in the direction of worse coverage without lower costs.

So why, one might ask, have MSAs been the major Republican positive proposal to improve health insurance; why has legislation to provide state support for MSAs been adopted in numerous states; and why did the Kassebaum-Kennedy bill include provisions that are designed to provide tax breaks for 750,000 MSAs?

One reason is, the idea fits Republican ideology and constituencies very well. The idea says tax cuts are the key to a better world. Moreover, MSAs in the short run could be a good deal for most healthy people — which means most people at any given time, and wealthier people more than poor people. The most obvious risk of MSAs, that a person without enough money in the savings account would have to do without services because the insurance would not be available until he spent his deductible, only applies to people who do not have the savings to make up the difference between the employer's MSA contribution and the deductible — namely, poorer people, who are more likely to be Democrats. But the idea is attractive to many, also, because MSAs offer savings without managed care. For perfectly good reasons that appeals to both individuals and physicians. Individuals would have wider choice of provider. Physicians think they would have more personal, and lucrative, relationships with patients.

Either academic MSA advocates or doctors would have to be unhappy with MSAs' performance in practice: if MSAs realized the inflated savings promises, physicians would see their incomes slashed. But physicians reasonably suspect that in a world of MSAs they would be in a better bargaining position, charging cash to people who have money in a savings account dedicated to health care, than they are in a world in which powerful payers negotiate lower fees. And even if MSAs saved the same amount of money for the system as managed care, physicians should get more because there should be fewer costs of management.

The more interesting question, then, may be why there is resistance to MSAs. Surely a sophisticated understanding of the biased selection problem cannot be the reason. Not in the political world. But MSAs are, naturally, deeply opposed by the major insurers that have invested heavily in managed care. Skepticism from the more informed policy community does matter, especially to Democrats. Moreover, the biased selection problem can be expressed rather simply: MSAs provide tax breaks for healthy people. The idea of high deductibles, per se, simply scares many people. Finally, the identity of MSAs' most fervent advocates, the right wing of the Republican party and the American Medical Association, creates distrust automatically.

The future of medical savings accounts in the United States remains to be seen. Perhaps experience with a limited population in MSA plans will resolve some doubts about their performance. Perhaps not.²³⁷ In any case, adoption of a measure that even in a limited manner fragments the risk pool, reduces the amount of health care reimbursed by insurance, and focuses attention on individual savings rather than collective solidarity,

shows how far the American debate has traveled from the assumptions of the Clinton proposals. It also puts the difference between the United States and Canada in sharp relief.

3.2.- Tightening and Restructuring Budgets in Canada

The dominant fact of current health policy in Canada is governments' effort to limit or even reduce spending. The dominant tension involves how this can be done without significantly reducing the guarantee of care within each province.

As Carolyn Tuohy argues, relatively generous funding and maintenance of physicians' clinical discretion were part of an implicit concordat between the state and health care providers:

"The accommodations between the state and health care providers have resulted in a system that is extraordinarily popular with Canadians, whether that popularity is viewed in comparison to Canadians' attitudes toward other public programs or in comparison to the attitudes of citizens of other nations toward their health systems. Medicare has become a defining feature of Canadian public mythology; and even more than is the case in other nations, tampering with the accommodations that underlie it carries great political risk."²³⁸

This accommodation depended, however, on fairly generous spending. In 1994, total public sector spending declined for the first time in the system's history, and increases had slowed dramatically as of 1992.²³⁹ As Tuohy explains,

"although health care spending has been protected in most provinces relative to other areas of public spending, the health care arena has nevertheless experienced what [Rudolf] Klein described in the British case as "relative deprivation over time." In Britain, this relative deprivation precipitated a breakdown of the "implicit concordat" between the medical profession and the state, which in turn triggered Margaret Thatcher's personal intervention and set in train the process that led to the "internal market" reforms of the early 1990s."

That exact process cannot occur in Canada because the federal government's role is more limited, while the provinces, in turn, still are limited by federal policies. Nonetheless, the strains are clear in public attitudes towards the system, which became less positive between 1988 and 1994. "To the extent that accommodations are unraveling and public satisfaction with the system is declining," Tuohy notes, "...it may be that Canada, after enduring the rhetoric of crisis in health care for years, is really entering a critical phase."²⁴⁰

The ability of governments to make major changes in the guarantee of care is, however, limited by that guarantee's popularity. The most obvious strategy, therefore, is to continue to squeeze the hospitals and physicians and hope the public perceives no decline in services. As explained in chapter two, Canadian provinces in the 1990s have tightened their use of such measures. The strains from that process, however, have proven at least sufficient to cause governments and providers to look for alternatives. As spending has fallen, public opinion of the system has also declined. Thus in one national poll, the proportion of people describing Canadian Medicare as "excellent" fell from 26 percent to 14 percent over five years. The data still shows over three quarters of the public describing the system as "good" or better, and clear majorities against privatization proposals. Yet concern has clearly increased, and with

it perceived declines in service quality, especially in the form of waits for hospital services.²⁴¹

In the attempt to avoid either major alterations of the Canada Health Act or simply substantial declines in quality within that Act's guarantees, Canadian provinces have implemented or discussed a wide array of measures from the international health care reform playbook. They even are considering versions of selective contracting. In the rest of this chapter we will review those incipient developments, and conclude by speculating on their future.

3.2.1.- *Devolution*

In 1992 only one province, Quebec, had devolved authority for health care to sub-provincial levels with any meaningful resource allocation powers. By 1996 all provinces except Ontario had devolved some authority; there were 117 regional authorities for health, all with some resource allocation powers.²⁴²

How much resource allocation power has been devolved is another matter: the basic answers are, "it varies," and, "not so much." In British Columbia regional health boards were supposed to allocate budgets to community health councils but not to hospitals. The program, however, was suspended in 1996. In Alberta the 17 new Regional Health authorities have much more responsibility, but substantial hospital finance authority remains at the provincial level, as is control of physician fees. Saskatchewan made a provincial decision to close hospitals and devolved to thirty district boards only after enforcing those closures. The district boards are not believed to be more objective than the provincial Ministry. "With district health boards deciding on the allocation of resources," one critic commented, "you get decisions based on what town's hockey team you like." And the district boards are accused of being a new layer of bureaucracy. In Quebec regional re-organization plans must be approved by the Health Minister, and budgets have not quite been regionalized.²⁴³ In all cases, the main squeeze on hospitals and services in general is coming from above, while no regional boards have any authority over physician services.²⁴⁴

In many cases, the new regional boards have been consolidated from among many smaller boards. So is devolution decentralization? Yes and no. Essentially, local boards which covered too small a set of facilities to have any significant power to allocate among facilities are being replaced by regional boards that cover enough facilities so that one can imagine boards allocating resources among them. But the provincial governments still determine the regional boards' budgets, and make most of the major decisions. In some cases the regional boards will have some significant authority within the limits set by provincial health ministries. In Saskatchewan, the province has developed a formula for budget allocations to the boards, thus reducing provincial discretion (if followed).²⁴⁵ Yet regionalization is mainly a blame-avoidance device; as the editors of *Maclean's* summarized,

"What is little understood is that the federal government took fully \$7.2 billion out of the system in 1995-96 and, with precious little debate, has gotten away with dumping the consequences at the doors of the provinces. They, in turn, have largely washed their hands of those consequences, leaving a series of unelected regional health authorities to cope with the impact. In New Brunswick last year, one cabinet member told an unpaid citizen-volunteer on a community health board that **she** could damn well go to a meeting of angry residents to explain recent cutbacks- but **he** was not attending any more gripe sessions."

The financial figure may be a bit overstated, and not all boards are unelected, but the basic political dynamic is right.²⁴⁶

Unless one is a total cynic, it may be striking that so many provinces would pursue a path for which there is little evidence of success. As Jonathan Lomas notes, there are no evaluations in Canada or elsewhere which show that devolution can achieve cost containment, improved efficiency, increased quality, or health improvement. Moreover, the notion that "the community" wants or will participate in regional boards is a myth. Lomas has survey data showing that 63 percent of the public thought "Health Care experts" should make health planning decisions, rather than "people in the community." Board members tend to be much more highly educated than the average, have higher incomes, and be twice as likely to be employed in health care.²⁴⁷

Why, then, is the regionalization effort so widespread? Lomas suggests a set of reasons that may well apply worldwide. First is the false belief that "it works." Second is the opportunity for governments to diffuse blame (I would put that first!). Third, the seeming populism of devolution makes it hard to oppose. It is especially attractive to leftist, "community" groups. Fourth, governments have to do *something*. Fifth, it looks like downsizing government, which makes the right wing happy. Last, there is a confusion between local control and local input; if the budgetary strings are not really loosened devolution may provide the latter, but pretend to provide the former.²⁴⁸ These reasons seem sufficient to justify a prediction that at least the form of regionalization will be strengthened in the future; the performance is entirely unpredictable.

3.2.2.- Supply-Side Measures

One argument for devolution is that it would move resources from hospitals to community health programs, because the regions would respond to community desires for that financing. Evidence of such desires on the part of the broad public is remarkably scarce worldwide. Nevertheless, Canadian provinces have not been waiting for action by regional boards to transfer resources out of the hospitals to extended care beds, home health, and other services.

In Alberta, RHAs received maximum expenditure limits on acute care and minimum limits for community services and community rehabilitation. Health spending was cut by 12 percent over three years (and that is not counting inflation). Saskatchewan increased funding for community-based programs and infrastructure, while cutting its number of acute care beds from 4.63 per 1,000 persons (which was too much) to 3.34 per 1,000. Ontario froze or cut spending for virtually all categories except community health services, while closing almost a quarter of acute care beds. It has planned to close a further 20 percent of the remaining beds. Nova Scotia shifted resources from acute facilities to home-care, long-term care, and emergency services. Quebec planned for the merger of acute care facilities in Montreal and Quebec City, with some bed capacity then being converted to long-term care. Approximately 4,000 out of 23,000 hospital beds are to be closed.²⁴⁹ Spending on hospital care in British Columbia was at essentially the same level as in 1992, while spending on "preventive care" rose by 57 percent.²⁵⁰ In the rationalization of the system, rural facilities are particular targets, on the theory that many of the services can be done both better and more cheaply in the cities. Naturally, citizens in rural areas are not convinced of that.²⁵¹

Provinces also have taken stronger measures to control the supply of physicians. These measures have two goals: to reduce the pressure for more services that comes with having more physicians, and to reallocate physicians from urban to rural areas.

While gross statistics of the form reported in chapter one do not show significant outcomes between more and less urban provinces, there is no doubt that within each province a shortage of physicians in rural areas is perceived to be a significant issue.

With total physician spending more or less capped, existing physicians have become more accepting of the effort to reduce the influx of new physicians. Medical school enrollments are being reduced. Among the provincial measures, Alberta has restricted issuance of billing numbers for new doctors. Ontario has instituted a temporary moratorium on new numbers for doctors trained outside of the province, and restrictions as well on entrance by foreign medical graduates. New Brunswick has set regional caps on physician supply, enforced by refusing hospital privileges beyond the caps. Prince Edward Island and Newfoundland only allow certain physicians who start new practices to collect fifty percent of the standard fees.²⁵² In a number of these cases the restrictions do not apply to rural areas, or are set at a level that would allow expansions in rural but not in urban areas.

These provincial measures may backfire because they undermine nationwide efforts to rationalize physician training. No province should expect to train only its own supply of physicians, especially since existing training capacity has not been created with that in mind. Morris Barer and his colleagues provide a nice example of what can go wrong. Ontario has always exported new medical graduates to the rest of Canada. If it bans imports, and other provinces retaliate, then Ontario's graduates will all try to practice in the province, increasing the local supply of doctors further! In this case a stronger federal role or more provincial cooperation seems called for, but may be difficult to achieve.²⁵³

From a policy perspective, the basic issue about supply-side measures is not whether, if strong enough, they can limit costs. Restraints on hospital capacity do work. The issue at present is whether any new measures exist that would improve performance for a given level of spending, for instance by funding "community care" or rural areas at the expense of hospitals or urban areas. If so, governments can freeze or even cut spending while maintaining or even improving outcomes.

That is basically a matter of values, since there are no agreed measures of the achievements of hospital and "community" care, or of the importance of various results for rural and urban populations. Basically, some people believe shifts of resources out of the hospital sector must be good, while others disagree. The former are winning, in Canada and many other countries. Yet it is not a question of efficiency at all, but a matter of different personal utilities. And the utilities that seem to matter are those of policy analysts, not the public.

In public complaints about health care, after all, it is the presence of waiting lists for hospital services, not the absence of "community-based care," that seems to get the most attention. Perhaps public fears would be increasing more slowly in Canada if people felt they were actually getting more home health care or whatever services in return for having hospital services made less easily accessible. But it does not really matter whether public suspicion is based on the public being less interested in "prevention" and "community" than in hospital services, or on the public not believing it's getting any more of the former. In either case, the public is showing distrust of policymakers' claim to be making things better by cutting the hospitals.

3.2.3.- *Heading toward America ?*

As the fiscal strains on Canada's implicit concordat increase, the quality of the Canadian system could decline directly. In the extreme, it might become more like the United Kingdom's. But it could also become more like the United States. This could

occur in two ways: an increase in the role of private payment, or some move towards managed care.

The Canadian Medical Association remains interested in encouraging extra-billing and the substitution of private insurance for public. In a 1993 statement it called for governments "to permit the emergence and development of both alternative and complementary private health insurance to meet the varied needs of patients and physicians, particularly in matters of free choice, access, availability and quality."²⁵⁴ In other words, people who have more money so can afford private insurance should be able to use that to satisfy their greater need for quick access.

This approach still seems unlikely. Outside Alberta, provinces have not even challenged the extra-billing restrictions of the Canada Health Act, and the amount of money involved in Alberta was small. Canada still has an unlegislated safety valve: rich people can go to the US for elective surgery. It is used far less than critics of the Canadian system in both Canada and the US would like people to believe; it also does Canadian doctors no good. Still, it must diminish any desire among wealthier Canadians for the privilege of paying extra for private insurance to cover benefits already covered by the provincial plans.

Moreover, private insurance already does exist for most people, through their employment, and its costs are growing faster than the public plans. The increased private sector share of health expenditure in recent years is an increase in benefit costs for employers, and the prospect that their employees might demand coverage for services whose costs are presently spread across the tax base for the provincial plans does not make them happy. If anything, the calls for privatization make the business community more interested in maintaining the principles of Canadian medicare, while also making it potentially supportive of reforms to make medicare more efficient.²⁵⁵

If Canada's health care is to become more like that of the United States, therefore, that is more likely to be in the form of some move towards "managed care" than a direct decline in public insurance. As mentioned in chapter two, public insurance may be explicitly reduced only to a very limited extent, through delisting "unnecessary" services. But subtler versions of that dynamic, in which physicians free themselves to sell services outside the budget cap, may occur in the guise of managed care.

The trick seems to be to develop practice guidelines. Physician associations are demanding cooperation in developing and establishing guidelines, as part of the deals in which they accept payment restrictions. The advantage for physicians seems to be, if a patient's condition does not meet the physician's personal judgment of need, and that judgment is backed up by a guideline, the doctor does not have to worry that another doctor will prescribe it, charge the provincial insurer, and thereby steal his patient. Even better, the physician may tell a patient that the guideline says the province will not pay under these circumstances, but that it might do some good in the patient's particular case, so it's up to the patient whether to pay for the extra care.

Guidelines, then, are a form of limited delisting. They should have a different effect when promulgated for all insured medical practice in an area, as in Canada, than when different payers have different standards, as in the United States. In the US guidelines are more of an administrative burden just because of the difficulty of keeping track of their variety. But they also cannot be as acceptable to patients: no individual plan's rules can have the authority of a province-wide regulation endorsed by the provincial medical association. They also are imposed in the context of overall spending caps in Canada, so physicians have particular need for both excuses for doing less and controls on each others' tendency to proliferate services.

It is easy to see why interest in creating provincial agreements on guidelines is very high. Yet Canada has not gone so far down that road as some American payers. The effort (and physicians' acceptance of it) is relatively new. Also, developing a guideline at a provincial level is harder than developing one within a much smaller, entrepreneurially managed, plan. Competing plans can tell physicians to accept or exit; provincial plans, negotiating with the provincial medical society, must allow physicians a time-consuming "voice." And getting a large number of physicians to agree on guidelines is difficult.

Greater use of guidelines would be an expansion of "managed care." It is likely to happen. Yet it would not be a major change in medical practice or payment arrangements. Creation of some form of selective contracting arrangements would be much more significant, and interest in those approaches is increasing.

Group practices are nothing new in Canada. Saskatchewan and Quebec created salaried community clinics in the 1960s. There are "perpetual pilot projects" in Ontario. But these methods of practice were popular with neither patients nor physicians.²⁵⁶ Doctors now, however, have a new incentive to reconsider their attitude: the trap created by serious caps on a fee-for-service payment mechanism. Under those caps, individual doctors are tempted to proliferate services to increase their incomes, but if they all do so, all work harder and none benefit. In economic terms, from a system-wide perspective, this is a virtuous version of the "tragedy of the commons": all the medical cattle graze more intensely, but none consume any more grass.

Policymakers are attracted by the prospect that selective contracting might, as in the Kaiser form of HMO, be more integrated care. Then policymakers might achieve caps on spending in a context that encourages someone who actually treats patients to try to integrate care in a way that maximizes benefits to a patient within the cap. Leftwing healthcare activists see integrated plans as a way to reduce the power of physicians and encourage community services. Physicians might not be attracted to quite the same measures as other policymakers, but they all can express interest in "alternatives" to fee-for-service.

Therefore interest in such reforms has been demonstrated in both academic discussion²⁵⁷ and provincial agreements with physicians. In 1995, the Canadian College of Health Service Executives reported that in British Columbia, "an alternative payment mechanism for physicians is currently being developed." In Saskatchewan, "the Health Department, in conjunction with the district health boards and/or physician groups, continue to develop pilots for alternative physician payment systems." In Quebec, "Discussions [were] initiated to move from fee-for-service to block funding for specific groups of physicians." Ontario planned "expansion of alternative funding plans." New Brunswick created an "Alternative Payment Mechanism Committee including government and Medical Society Membership." In Nova Scotia, the agreement between the government and Medical Society included agreement to "Develop an innovative system for providing medical services." In Prince Edward Island, "joint efforts are being made with the medical society to examine how physicians can move to a salaried model."²⁵⁸ Interest, however, has yet to be matched by institutional change. Morris Barer and his colleagues give a plausible account and explanation:

"Global expenditure caps on fee-for-service practice induced a rush of interest from within the medical profession in alternative payment mechanisms such as sessional fees in low-volume emergency rooms, salaries for academic faculty, and capitation for primary care physicians. Unfortunately, the global expenditure caps have

tended to entrench or insulate a pool of fee-for-service funds. The medical profession, of course, wished funds for alternative payment mechanisms to be add-ons. Not surprisingly, Ministries of Health insisted that such funds be extracted from the fee-for-service pool (anything else would have made a mockery of the notion of a global cap). Joint management structures became the sites where this battle was fought. It has generally ended in stalemates, to the frustration both of Ministries of Health and physicians genuinely interested in alternative payment mechanisms."²⁵⁹

Although the incentives for change are growing, they are not yet strong enough to overcome doubts about it. The benefits certainly do not seem so great that either side in the negotiation would be willing to accept conditions that seem unfavorable. Nor is there evident public support for restricting choice. The Canadians have not even gotten to the point of having to seriously consider the risk-adjustment problems.

Canadian interest in selective contracting could be expected to increase if the record of those methods in the United States improves. The discussion of selective contracting demonstrates the basic appeal of internal market ideas worldwide, and the specific effects of capped fee-for-service payment upon physicians. Yet the very method by which selective contracting has been considered demonstrates a huge gulf between Canadian and American health care policy. In Canada, change is a matter of political agreement, subject to negotiations between the province and organized providers, and dependent ultimately on approval by a majority of voters. In the United States, the organization of health care finance allows the system to be reorganized by private interests in a context of uncoordinated action by public officials.

3.3.- Convergence and Divergence of Health Care Policy

This chapter's review of reform proposals and prospects in the United States and Canada provides more examples of failure than success. Rich countries are the same as poor countries in some ways!

It demonstrates a convergence between otherwise dissimilar systems at the level of both problems and discussion. Each faces what is believed to be a crisis of cost control. In each, policymakers are trying to move people out of hospitals, cut hospital capacity, and restrain physician supply. In each, an agenda of cutting hospitals in order to build some form of more "integrated" delivery system has been circulating in policy discussions for a long time. In each, a fiscal crunch has enabled payers to cut the payments to hospitals in the name of creating greater integration, but whether they are actually doing the latter is quite doubtful. In each, versions of selective contracting are gaining a larger place on the policy agenda.

Yet the two nations start from very different places, and it is not at all clear that they are getting closer. In spite of all the stresses, Canada's guarantee of universal coverage seems threatened less than America's lower level of insurance. Increased talk about selective contracting does not compare to the implementation of selective contracting in the United States. Capacity is being reduced in a much more measured way in Canada. The gap between the two countries in both costs and levels of insurance has widened, not narrowed.

If this chapter has any broad lesson, then, it is a simple one: in health policy, watch what people do, not what they say.

Endnotes for Chapter 3

¹⁷⁵ For accounts of the health care reform debacle from both policy and political perspectives, see Joseph White, *Competing Solutions* (Washington: The Brookings Institution, 1995); Theda Skocpol, *Boomerang: Clinton's Health Security Effort and the Turn against Government in U.S. Politics* (New York: W.W. Norton, 1996); Haynes Johnson and David S. Broder, *The System: The American Way of Politics at the Breaking Point* (Boston: Little, Brown 1996); *Health Affairs* (Summer, 1995); and the articles by Sven Steinmo and Jon Watts and by myself in *Journal of Health Politics, Policy and Law* (Summer, 1995). The claims made here about Clinton's substantive dilemmas are explained more fully in *Competing Solutions*.

¹⁷⁶ People interested in the basic conception should see Paul Starr and Walter Zelman, "A Bridge to Compromise: Competition Under a Budget," *Health Affairs* 12 (Supplement, 1993) pp. 8-23.

¹⁷⁷ For accounts of the basic ideas see Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs* 12 (Supplement, 1993) pp. 24-48; Paul M. Ellwood, Alain C. Enthoven, and Lynn Etheredge, "The Jackson-Hole Initiatives for a Twenty-first Century American Health Care System," *Health Economics* 1:3 (1992), pp. 149-68; Alain Enthoven and Richard Kronick, "A Consumer Choice Health Plan for the 1990s," *New England Journal of Medicine* in two parts, January 5, 1989 pp. 29-37, and January 12, 1989, pp. 94-101. Readers may note that the emphases are not identical in all versions, perhaps due to different collaborators.

¹⁷⁸ I can attest from personal conversations that even some very authoritative analysts spent days and weeks puzzling out how the premium regulations would actually work, and had trouble believing it when they figured it out.

¹⁷⁹ All numbers from budget debates depend on the exact stage of the political process and the estimates in use at the time. Here I use CBO's August, 1995, projection of total federal spending for fiscal years 1996-2002, as reported in Congressional Budget Office, "The Economic and Budget Outlook: An Update," Table 9. The proposed tax cut kept changing as Senate Republicans and House Republicans negotiated with each other. For political purposes, the most important figure was the cost of the tax cut proposed in the Republicans' "Contract With America" pre-election manifesto. The House Budget Committee estimated that cost, as endorsed in the House Budget Resolution, at \$281 billion over seven years. See press release, "Republicans Meet Challenge, Present Plan to Balance Budget," May 9, 1995.

¹⁸⁰ Here I am calculating shares based on the figures available at the time Republicans devised their budget plans in early 1995, from CBO, "The Economic and Budget Outlook: Fiscal Years 1996-2000," January, 1995, Tables 2-6, 2-14; see also text at p. 57.

¹⁸¹ Here the calculation is based on the revised baseline from August, as reported in CBO, "The Economic and Budget Outlook: An Update," Table 14.

¹⁸² Author's calculation as of December 18, 1995, based on CBO reports of spending targets, of baselines at earlier dates, and of adjustments from those baselines. The figure could be off by a fraction of a percent.

¹⁸³ The estimate comes from *State Initiatives in Health Care Reform* (Jan/Feb 1996), p. 2; state experience in fact varies greatly.

¹⁸⁴ See Henry Aaron and Robert Reischauer, "The Medicare Reform Debate: What is the Next Step?" *Health Affairs* 14:4 (Winter, 1995) pp. 8-30.

¹⁸⁵ We will discuss MSAs a bit below; for an analysis see Joseph White, "Medical Savings Accounts: Fact vs. Fiction" *Brookings Institution Working Paper* (June, 1995).

¹⁸⁶ Since Clinton's plan kept changing, and the baseline also changed with new economic and technical estimates, no single comparison is appropriate. At the latest stage of the process, at the end of January, 1996, the administration was proposing \$124 billion in Medicare reductions and \$59 billion in Medicaid

cuts. The new Republican proposals were down to \$168 billion from Medicare and \$85 billion from Medicaid. As late as the beginning of January, 1996, however, the Republicans were proposing \$201 billion from Medicare and \$116 billion from Medicaid, while the administration was proposing \$101.5 billion from Medicare and \$51.7 billion from Medicaid. These figures are from a set of unpublished background comparisons prepared by the Congressional Budget Office.

¹⁸⁷ *BNA's Health Care Policy Report*, April 1, 1996, p. 637.

¹⁸⁸ Milt Freudenheim, *New York Times*, April 29, 1996, p. A1.

¹⁸⁹ Steven Lipin in *The Wall Street Journal*, June 10, 1996, p. A3.

¹⁹⁰ Robert Tomsho, *Wall Street Journal*, May 1, 1996, p. B1.

¹⁹¹ Milt Freudenheim, "For Blue Cross, At Crossroads, A Fight to Save Role for System," *The New York Times* June 12, 1996, p. D1; also, "Health Plans In New Jersey Face Rivalries," May 30, 1996, p. D1.

¹⁹² Paul B. Ginsburg, "Introduction and Overview," *Health Affairs* 15:2 (Summer, 1996), quotes pp. 15-17.

¹⁹³ Ginsberg, "Introduction and Overview," p. 14.

¹⁹⁴ Kathryn Saenz Duke, "Hospitals In A Changing Health Care System," *Health Affairs* 15:2 (Summer, 1996) p. 55.

¹⁹⁵ Ron Winslow, "Switch to HMO Care Can Be Turbulent, As AT&T Case Shows," *Wall Street Journal*, May 9, 1996, p. A1.

¹⁹⁶ American Hospital Association figures, reported in *BNA's Health Care Policy Report*, May 27, 1996, p. 909.

¹⁹⁷ Spencer Rich, "At Hospitals, Cutting Costs or Corners?" *The Washington Post* May 27, 1996, p. A6.

¹⁹⁸ Peter T. Kilborn, "Feeling Devalued by Change, Doctors Seek Union Banner," *The New York Times* May 30, 1996, p. A1; Ron Winslow, "Doctors' Average Pay Fell 4% in 1994 With Drop Attributed to Managed Care," *Wall Street Journal*, Sept 3, 1996, p. B6.

¹⁹⁹ Stephanie N. Mehta, "Smaller Firms Eased 1995 Health Costs By Switch to Managed Care, Study Says" *Wall Street Journal* July 10, 1995, p. B2. There has long been a suspicion that the most successful HMOs, like Kaiser, engaged in "shadow pricing": setting their prices higher than they needed to be but somewhat below, in the shadow of, indemnity plans in the same market. If true, this was entirely rational behavior; setting prices lower would have provoked many new enrollments, threatening to overwhelm the capacity of a clinic-based system. Shadow-pricing would generate the capital for a slower and more manageable expansion. It would also mean that, once it faced new competition, an HMO like Kaiser would have been able to lower prices to retain market share (as opposed to increasing it) relatively easily. That fits experience in California when the California Public Employee Retirement System began demanding lower premiums and targeted Kaiser in particular in 1992. To the extent that premium constraints have been based on squeezing this margin out of existing HMOs, it should have little effect on quality of care; but that process should also have a natural stopping point.

²⁰⁰ The report listed many of the reasons that would involve transfers of costs to employees rather than greater efficiency of care, but the data cited was not up-to-date. *Faulkner & Gray's Medicine & Health*, August 5, 1996, p. 3.

²⁰¹ Thomas M. Burton, "United HealthCare Unveils Profit Plunge," *Wall Street Journal*, July 12, 1996, p. A3. United HealthCare's problems were mainly in its fee-for-service products, but higher than expected cost increases there may signal changes in providers' dealings with health plans — such as higher charges by drug companies.

²⁰² Personal conversations in 1994 and also in his presentation at the First Annual Managed Health Care Leadership Summit, Mexico City, September 9, 1996.

- ²⁰³ The quotations are from *Health Care Financing & Organization News & Progress*, March 1996, pp. 1, 3.
- ²⁰⁴ Ginsburg, "Introduction and Overview," p. 15.
- ²⁰⁵ The estimate is from a study by Ken Thorpe for the Robert Wood Johnson Foundation's Council on the Economic Impact of Health System Change, reported in *Advances* 9:1 (Winter, 1996)
- ²⁰⁶ Ginsburg, "Introduction and Overview," p. 18; Oberlander, "Managed Care and Medicare Reform," pp. 32-33.
- ²⁰⁷ *State Initiatives in Health Care Reform*, July/August 1995, pp. 7-9, 12; also personal conversations with CBO and GAO staff.
- ²⁰⁸ *State Health Watch* April, 1996, p. 9 (Ohio); May, 1996, p. 2 (New Jersey and Missouri).
- ²⁰⁹ *BNA's Health Care Policy Report*, June 3, 1996, p. 937; *State Health Watch* May, 1996 p. 3 (Kaiser limited its participation to 4,000 beneficiaries).
- ²¹⁰ *State Initiatives in Health Care Reform*, May/June 1995, pp. 5-6.
- ²¹¹ David Brown, "Deluged by Medicaid, States Open Wider Umbrellas," *Washington Post*, June 9, 1996, p. A1; see also, "When Specialists Aren't the Norm," June 10 p. A1; "Turning Away Patients as a Way to Survive," June 11 p. A1.
- ²¹² *State Health Watch* April, 1996, pp. 3, 9; the nursing home payment reform "is estimated to save \$473 million a year in a roughly \$6 billion Medicaid budget."
- ²¹³ For example, at one point there were 699 such pairs, of which 565 were to be funded; Daniel M. Fox and Howard M. Leichter, "The Ups and Downs of Oregon's Rationing Plan," *Health Affairs* 12:2 (Summer, 1993) pp. 66-70. For an early account, see Martin A. Strosberg, Joshua M. Wiener, and Robert Baker, with I. Alan Fein, eds., *Rationing America's Medical Care: The Oregon Plan and Beyond* (Washington: The Brookings Institution, 1992); see also Jean I. Thorne, Barbara Bianchi, Gordon Berryman, Clark Greene, and Tricia Leddy, "State Perspectives on Health Care Reform: Oregon, Hawaii, Tennessee, and Rhode Island" *Health Care Financing Review* 16:3 (Spring, 1995) pp. 121-38.
- ²¹⁴ *State Health Watch* May, 1996, p. 10. Among other reasons, Kaiser-Permanente officials threatened to withdraw from the plan if the list were shortened. One may imagine that for an HMO that normally provides comprehensive coverage, rationing care based on such a list must be difficult. It would be especially difficult if a patient had comorbidities: a condition on the list and one not on the list.
- ²¹⁵ Brown, "Turning Away Patients as a Way to Survive." Also *State Health Watch* May, 1996, p. 1; Elisabeth Rosenthal, "Private Hospitals in New York Signal A Deepening Crisis," *New York Times* June 4, 1996, p. A1; Maryland is a relative exception to these trends; see *State Initiatives in Health Care Reform* May/June 1996 pp. 5-7.
- ²¹⁶ For a good summary, see Marilyn Werber Serafini, "Reining In the HMOs," *National Journal*, Oct. 26, 1996, pp. 2280-83.
- ²¹⁷ *Faulkner & Gray's Medicine & Health* July 1, 1996 p. 3; *BNA's Health Care Policy Report* July 29, 1996, pp. 1226, 1242-43.
- ²¹⁸ Ron Winslow, "Humana Lifts Rules Limiting Doctors' Speech," *Wall Street Journal*, Oct. 29, 1996, p. B5; Spencer Rich, "HMO Industry Moves to Allay Patient Worry on Care Quality," *Washington Post*, Dec. 18, 1996, p. A2.
- ²¹⁹ *BNA's Health Care Policy Report*, July 29, 1996, p. 1228.
- ²²⁰ *BNA's Health Care Policy Report* April 15, 1996, pp. 665 (Georgia) and 666 (Tennessee); May 20, 1996, p.863 (Connecticut, New Hampshire, Iowa, Arkansas); July 29, 1996, pp. 1227 (Illinois) and 1228 (Ohio).

²²¹ Laurie McGinley, "Maternity-Stay Bill Has Good Chance Of Passage Among Health Measures," *Wall Street Journal*, Sept. 17, 1996, p. A20; Robert Pear, "Congressional Leaders Agree on New Insurance Proposals," *New York Times*, Sept. 20, 1996, p. A20; Stuart Auerbach, "Expanded Health Care Not a Cure-All for Costs," *Washington Post*, Sept. 21, 1996, p. B1.

²²² Robert Pear, "Managed Care Officials Agree To Mastectomy Hospital Stays," *New York Times*, Nov. 15, 1996, p. A30; Laura Johannes, "More HMOs Order Outpatient Mastectomies," *Wall Street Journal*, Nov. 6, 1996, p. B1; Lauren Dame and Sidney M. Wolfe, "Truly Radical Mastectomies," *Washington Post*, Sept. 24, 1996, p. A17.

²²³ George Anders, "Kaiser Permanente, Doctors' Group Seek Greater Coverage of Emergency Service," *Wall Street Journal*, Aug. 19, 1996, p. A2. I should note that I have been in exactly this situation when I followed doctors' orders to go to the emergency room if I had an incident of heart palpitations that lasted for more than a few minutes. It would die down briefly and then return, over a period of more than an hour. But by the time I was finally seen in the emergency room, it did not come back in a way that could be observed on the monitors. So my insurer refused to pay. It did pay after a protest.

²²⁴ James Dao, "Pataki Offers Plan to Help H.M.O. Clients," *New York Times* May 9, 1996, p. A1.

²²⁵ Ellwood et al, "The Jackson Hole Initiatives,"; Enthoven, "The History and Principles of Managed Competition."

²²⁶ *State Initiatives in Health Care Reform*, No. 20 (October, 1996) pp. 1-4.

²²⁷ *Health Care Financing & Organization News & Progress* July, 1995, pp. 1-4.

²²⁸ For a review of similar judgments, see *ibid*.

²²⁹ Thus in California, with over 30 million residents, the state small business pool had 105,000 members as of March 1, 1996. *BNA's Health Care Policy Report* April 22, 1996, p. 699.

²³⁰ *BNA's Health Care Policy Report*, June 17, 1996, pp. 1019-20.

²³¹ *State Initiatives in Health Care Reform*, May/June 1996, p. 9; *State Health Watch*, April 1996, p. 1.

²³² The summary that follows is based on Dave Skidmore, "Understanding the Kassebaum-Kennedy Health Coverage Bill," *The Washington Post* August 19, 1996, p. A13; *BNA's Health Care Policy Report*, August 5, 1996, pp. 1251-53; and the bill text.

²³³ There is a good policy reason not to simply guarantee issue under all conditions. Individuals might exploit that by choosing not to buy insurance until they were sick. Therefore it makes sense to provide incentives for people to buy insurance when they are healthy. The simpler approach, of course, is just to compel everyone to contribute to the insurance system.

²³⁴ *BNA's Health Care Policy Report* August 5, 1996, p. 1251.

²³⁵ The deduction for the self-employed would rise to 40 percent in 1997, 45 percent in 1998, 50 percent in 2003, 60 percent in 2004, 70 percent in 2005, and 80 percent in 2006, at an estimated cost of \$6.4 billion over ten years; the long-term care provisions were estimated to cost \$10.9 billion over ten years.

²³⁶ The following account of the logic and flaws of MSAs is based on Joseph White, "Medical Savings Accounts: Fact vs. Fiction," *Brookings Working Papers* June, 1995.

²³⁷ Personally, I would like to be assured that the plans will in fact be comparable; at present it is not clear how many supposed examples of MSAs in fact have similar incentive structures. Any analysis, also, must somehow be based on a risk adjustment that we do not know how to do with much confidence — and may not have the data to do.

²³⁸ Carolyn Tuohy, "Health Reform, Health Policy - Towards 2000. Canada in Comparative Perspective" paper prepared for the Four Country Conference, Montebello, Quebec, May 16-18, 1996. p. 4.

²³⁹ Health Canada, *National Health Expenditures in Canada 1975-94, Highlights*, Table 2.

- ²⁴⁰ Tuohy, "Health Reform, Health Policy" p. 5.
- ²⁴¹ See *Maclean's*, Dec. 2, 1996, pp. 48-49. See also the report of a poll sponsored by the Canadian Medical Association in *BNA's Health Care Policy Report*, May 27, 1996, p. 913. Although one need always be cautious about polling by an interested party, the results seem plausible. For instance, respondents perceived much larger increases in waiting time for hospital services (over fifty percent) than for home health or family doctor services — which fits the budgetary pattern.
- ²⁴² Remarks of Jonathan Lomas at 4-Country Conference, Montebello, Quebec, May 16, 1996.
- ²⁴³ *Maclean's*, Dec. 2, 1996, pp. 58-68; quote p. 60; Canadian College of Health Service Executives, "Special Report: External Environmental Analysis and Health Reform Update" Summer, 1995, pp. 24-27.
- ²⁴⁴ Tuohy, "Health Reform, Health Policy," p. 7.
- ²⁴⁵ Tuohy, "Health Reform, Health Policy" p. 7; CCHSE, *Special Report*, p. 24.
- ²⁴⁶ *Maclean's*, Dec 2, 1996, p. 2. The financing figure is the longterm cut under worst-case assumptions, though they might come true; as discussed in chapter one, the federal government certainly has been cutting its own costs at the provinces' expense.
- ²⁴⁷ Jonathan Lomas, remarks and distributed tables at 4 Country Conference, Montebello.
- ²⁴⁸ Ibid.
- ²⁴⁹ CCHSE, "Special Report," pp. 20, 21, 25, 37, 38; *Maclean's*, Dec. 2, 1996, pp. 59, 60, 62, 63.
- ²⁵⁰ Author's calculation from table of "Consolidated Revenue Fund Schedule of Expenditures by Function for the Fiscal Year Ended March 31 (Unaudited)" provided by staff of British Columbia Ministry of Health and Ministry Responsible for Seniors, dated 04 July, 1996.
- ²⁵¹ *Maclean's* Dec. 2, 1996, pp. 58-59, 66-68.
- ²⁵² Morris Barer, Jonathan Lomas, and Claudia Sanmartin, "Re-Minding Our P's and Q's: Medical Cost Controls in Canada," *Health Affairs* 15:2 (Summer, 1996) p. 222; CCHSE, "Special Report," pp. 30-31.
- ²⁵³ Barer, Lomas and Sanmartin, "Re-Minding Our P's and Q's," pp. 227, 234.
- ²⁵⁴ Canadian Medical Association, *Towards a New Consensus on Health Care Financing in Canada* Ottawa, July 1993, p. 1.
- ²⁵⁵ Tuohy, "Health Reform, Health Policy," p. 9. Even one of Canada's largest private health insurers advertised that, "The single-pay system — through which those core services are delivered by way of medicare — must continue." *Maclean's*, Dec. 2, 1996, pp. 50-51.
- ²⁵⁶ Tuohy, "Health Reform, Health Policy," p. 7.
- ²⁵⁷ For an example see Monique Jerome-Forget, Joseph White, and Joshua Wiener, eds., *Health Care Reform Through Internal Markets: Experience and Proposals* (Montreal and Washington, IRPP and Brookings, 1995).
- ²⁵⁸ CCHSE, "Special Report," pp. 30-32.
- ²⁵⁹ Barer, Lomas and Sanmartin, "Re-Minding Our P's and Q's," p. 225.

4.- CONCLUSION: EVIDENCE, CONDITIONS AND SPECULATIONS

The reasons to be cautious about drawing inferences from the United States and Canada for policymaking in other countries are legion. Much of their internal development is new enough that it is difficult even to be sure what one is observing, never mind its causes and consequences. They are only two countries, so not enough to prove anything. They are very different from the countries whose policymakers may seek lessons in this report. Indeed, their basic methods of health care financing are unusual even in the context of nations at similar levels of economic development.

The evidence they offer is, at best, the evidence that is possible from case studies. It is best considered in combination with the evidence from many other countries. Yet that broader comparison is not possible without preliminary judgments about these cases. Those judgments then are necessary to the collective effort of this conference, even though their tentative nature and limited support should be understood.

I have made a series of such judgments throughout the text of this report. In summarizing them here, I am somewhat more confident than the evidence of just these two cases would justify. A number of them seem, to me, to be confirmed by my understanding of the other national health care arrangements that I have studied.

Yet that other work also makes me aware that variations in some conditions may support other conclusions. This conclusion, therefore, is in two parts. In the first, I summarize what seem to me to be the major implications of the previous pages. In the second, I suggest why they might be modified for the purposes of policymakers in Latin America, and when they are better guides to policy.

4.1.- Major Implications of US and Canadian Experience

Within the worldwide debate about health care reform, one issue is how much health insurance and health services matter. This report has argued that neither insurance nor services can eliminate ill health, or inequalities in health. Health care and health insurance exist in order to reduce the misery caused by disease when it occurs. In doing so, however, they do improve health outcomes.

The comparison between Canada and the United States suggests that providing decent health services to all citizens is a more efficient method of improving health than allowing those who have more money to spend a lot more and allowing those with less to do without. Canada has better health results for substantially lower spending. Where the United States closes the gap most is among the population, the

elderly, who have universal health insurance within the United States. The differences in health care results between insured and uninsured Americans is substantial.

Allowing competition to sell health insurance, making purchase of insurance voluntary, and in general turning it into a market commodity creates a series of problems that make it more expensive and less accessible. These include not only administrative overhead but difficulties of biased selection on the part of both the sellers and the buyers.

Notions that such market competition can lead to a superior result in spite of those defects, because competition encourages "managed care," simply are not supported by the available evidence. Managed care, in its various forms, is not a superior alternative to the methods of cost control used by Canada and many other advanced industrial countries with universal health insurance coverage.

Because it does not create meaningful savings compared to other methods, competition in the United States also has not helped solve the basic problem of how to finance expansions of insurance coverage. One cannot blame American competition for the lack of universal insurance: the people who do not want to pay for other people might have the power to refuse in any case. But the ways Americans pay for care certainly have not helped matters.

The American version of competition is also creating significant risks of even less adequate services to some populations. In order to realize savings, managed care in a competitive system must abandon the ability to adjust the supply of medical services to the distribution of medical need. It may be an effective, but is basically a mindless means of capacity reduction. Methods of health service capacity management in a political process do not meet simplistic notions of rationality. Yet they are less risky than the methods of market rationality.

Having said this, however, I must caution that, while "managed competition" seems in many ways a very difficult thing to implement, **it has not even been tried in the United States.** The United States has unmanaged competition. While it is surely very difficult to control risk-selection and adverse selection, the United States takes virtually no measures to do so. While it is very difficult to create informed consumers, American competition, by allowing wide variation in the basic terms of the available plans, makes informed choice almost impossible. There is a large roster of controls on competition that were proposed by Alain Enthoven and his colleagues and are not even approached in the current American market. Most important, the competition in the United States occurs in a context in which there is no guarantee of insurance coverage. Internal market proposals in other advanced industrial countries start from universal coverage, and therefore involve far fewer risks to the adequacy of care.

Put bluntly, the American version of competition does not even provide much of a lesson to the Colombians, because Colombian policymakers have already tried to avoid some of the most egregious failings of the American market.

That having been said, we must remember that governments that coordinate payment for health care within a broad socialization of finance of care, as in Canada, can still make bad decisions. Just as the market allows policymakers to ignore the consequences of reducing spending, so does "devolution" or "decentralization." Whatever term one wants to use, putting the blame for decisions about the details of cuts on a lower level of government, while deciding on the total cut at a higher level, may help a government cut its obligations without acknowledging the consequences.

We see this dynamic in Canada as the federal government passes the buck (or fewer bucks) to the provinces and the provinces seek to put the blame on newly created regional authorities. We see it in the United States with the effort to de-entitle

Medicaid and make the states responsible for the program's terms. Clearly, to place at least seeming responsibility on some lower level of government is a very plausible political strategy. But it has few if any visible legitimate policy advantages, at least in American and Canadian experience. Federalism, in general, creates a special set of problems involving intergovernmental financing games, that do not seem to be offset by any benefits from the variation that federalism creates.

The more common international methods of cost control work in part because some common assertions about cost control are wrong. Regulating fees works. It works better if combined with some method to adjust fees to volume of services, but the common assumption that "price controls" for medical care must backfire is in error. Even supposed successes of managed care in the United States seem more a matter of managing fees.

As an analogous point, incomes matter. Much of the difference in costs between the United States and Canada is explained simply: hospitals and doctors in the United States charge more per service, and provider incomes therefore are higher. This does provide some solace for anyone who looks at the difference in wealth between the United States and Canada on the one hand and Latin America on the other, and concludes that the health care systems could never be comparable.

Inasmuch as the difference in raw dollars spent is due to differences in wage levels (and real estate prices!) between countries, it makes the difference between what is affordable in North America and Latin America seem larger than it really is. Those wages and rents, of course, will not be paid in Latin America. What matters for any given society is the wages of its health care personnel relative to the societal average, not compared to some other country. So Argentina or Chile could match some of the North American health care inputs so long as the compensation for providers was only similarly generous (e.g. five times the median wage for physicians) in relative terms. Unfortunately, that is only a partial consolation. If a country has a less equal distribution of income between upper and lower classes than in the US and Canada, relatively upper-class professionals may expect to make far more relative to the median wage than in North America. And every nation still must deal with the costs of training and especially of capital equipment. Supplies that have an international price will be much more affordable for North Americans than in Latin America; there the difference in dollar incomes does matter directly.

Whether we are looking at efforts to save money by focusing on prices, volume of services, capacity of the system or even appropriateness of treatment decisions, however, the extent to which any cost control measure works depends on elements of supply and demand. This is true even of government programs: American Medicare's fee-based cost controls work because it is a large payer, and the restrictions on extra-billing work better in areas with more physicians per capita. Put differently, supply and demand matter even if they are not being equilibrated by a market. That is why Canadian physicians have come to want to manipulate physician supply.

In each country, finally, policy changes depend on finding someone to pay the costs. President Clinton's health care reform failed because there was no costless way to expand coverage, and no way to overcome the opposition of those who would have had to pay for the expansion. Canadian health care cost controls have worked, so far, not because they are costless but because the costs to providers so far have seemed more significant than the costs to the public, and the public is more powerful. The providers, therefore, attempt to convince the public that its own care is threatened. Much of the logic of policy proposals in each country is an effort to hide or displace or in some way avoid blame for costs: thus the attractions of both devolution

and markets. In short, some policies are more nourishing than others, but there is no free lunch.

4.2.- Health Care Reform in Latin America

Some of these conclusions have direct implications for policy proposals in Latin America. Universal health insurance is worth pursuing. If methods of "managed competition" fail to create nirvana in a Latin country that is not because the country is doing something wrong that any other nation knows how to do right. Similarly, if devolution has few positive outcomes, that too is no surprise.

In certain ways these conclusions may be useful for all countries. To the extent that they refute myths about American or Canadian performance, they at least explain why some measures might not work as expected. Yet that does not mean that even all the conclusions that seem to have direct implications actually provide the proper advice about health reform in Latin American nations.

We must first recognize the huge differences within the Latin world, especially between the poorer nations, like Bolivia, and the richer ones, like Argentina or Chile. Some approximation of US and Canadian health services, though with substantially more rationing of services that depend on expensive equipment, may be achievable in Argentina or Chile; it is inconceivable in Bolivia. The former countries may be even more able to approximate the service levels of advanced industrial nations that spend much smaller shares of their national income on health care, such as the United Kingdom and Japan. It is possible to talk about reallocating their services to increase efficiency. In very poor nations, there are so few resources that hardly any allocation could be efficient. That may be why the World Bank model basically changes the subject, focusing on a small amount of care deemed to be socially useful, rather than trying to suggest ways to respond to the actual desires for treatment.²⁶⁰

In short, policy goals for Latin American health care reform may be different from the goals of policy in Canada and the United States, thus putting in doubt the relevance of evaluations of the latter to choice in the former. The plausible goals of reform in the very poor countries are so distant from the reality in advanced industrial nations that the latter's policy conundrums, and performance, may be largely irrelevant. Yet even the goals in richer Latin nations may be sufficiently different to justify different conclusions about some of the measures discussed above.

4.2.1.- *Deciding the Extent of Solidarity*

In comments on the first version of this paper, one reader asked for more discussion of "balancing solidarity with competition."

The interesting thing from this author's perspective is, that does not seem to be the real question in either the United States or Canada.

In Canada, there is little question of balancing solidarity with competition, because competition has yet to be allowed to operate in a way that could threaten solidarity. Canada has not allowed competition in the financing of health care: for the covered services, financing is entirely socialized, not only without competition but without costsharing. Nor has Canada allowed any selective contracting: for the covered services, payment is entirely by standard rules at the provincial level.

In the United States, meanwhile, the notion of "balancing solidarity with competition" is almost entirely rhetorical. President Clinton hoped to expand solidarity

with some managed competition, but failed entirely. There simply was not enough support for expanding solidarity. There are academics who would like to believe that somehow competition and solidarity could develop a positive synergy. But that is not what is happening. "Competition" is being driven in the private market by payers who have no interest in solidarity — if they can reduce their solidaristic obligations while saving money through competition, that will be fine with them. "Competition" by providers requires that they waste less money on solidarity in the form of charity care. Proposals to "protect" Medicare and Medicaid, making them more affordable, by allowing more competition are basically rationales for budget cuts. Eliminating the entitlement to Medicaid does not balance solidarity with anything; it simply reduces solidarity. Turning Medicare from a defined benefit plan into a defined contribution plan (which is what Medicare vouchers would do) would have much the same effect.

At the margins, for a small portion of the poorer population, in a situation where the fee-for-service medicine that was available to them was already quite flawed, and under unusual market conditions that have selective contracting firms eager to gain extra covered lives so as to improve their bargaining positions vis a vis providers, some more competition may improve solidarity in the Medicaid program. But in general, in order to talk about "balancing solidarity with competition," you have to have some reason to believe that competition has independent merits. And, in the comparison between the US and Canada, it is hard to identify what those merits might be.

If competition does not do a better job of cost control, and if it only creates even more risks to quality, what is the point of "balancing" it with anything?

One answer would be that, within some countries that already had socialized finance of care extensively, so had created universal coverage, the ways their health care delivery systems were organized meant that "competition" in the internal market form could improve services in a way that justified some risks to the equity of care. One could make that argument fairly credibly, for example, about the implementation of GP fundholding in the United Kingdom.²⁶¹

Yet in the context of many systems, and that probably includes many in Latin America, the real political point of "competition," as ordinarily defined, is that it is in opposition to solidarity. Competition means some people pay more and get more than others. Physicians and other providers like this because they expect higher incomes from those people who pay more. Richer people like this, because they would rather pay more to get more (or better service) for themselves, than pay more to provide more for others.

From this perspective, "balancing" solidarity and competition has nothing to do with efficiency or cost control or any empirical analysis. It is simply a calculus of social distribution. The question is not really "solidarity" vs. "competition," but simply how much solidarity to have. "Competition" is a more attractive way of saying "less solidarity."

One does not need to believe that "competition" has any intrinsic merit in order to accept some limitations on solidarity under some circumstances. Policymakers may legitimately conclude that some set of exceptions to solidarity is more politically and fiscally practical than an attempt to provide more solidarity. In essence, governments may seek to organize matters in such a way that, in return for the extra income from "competition," physicians contribute more willingly to the remaining solidaristic system, and so, in return for being able to opt into the more "competitive" world of fancier care, richer citizens grumble less at contributing to the solidaristic system.

Consider, for example, whether a national guarantee of insurance coverage should have to compete with private coverage for the same services. In Australia, unlike in Canada, private insurance may be purchased to cover hospital services that

are also covered by the national insurance scheme. The advantage of private insurance is, its purchasers are covered for hospital costs in private hospitals, which the public scheme does not reimburse, and also can get preferred status in public hospitals. Private insurance thereby creates clear inequalities: its beneficiaries wait less for services, and are likely to have easier access to more desirable physicians. The popularity of the Canada Health Act shows that Canadians would be quite unlikely to accept Australian arrangements.

Yet the supplementary private insurance does allow the Australian government to spend less on health care than would be necessary to provide comparable services without the private payments. Arguably, those savings allow support of other national needs. Reducing inequality of health care access seems to be a less paramount goal in Australia. So the advantage of Canadian institutions is a matter of values. But it is also, perhaps more importantly, a matter of the conditions one is living with when evaluating two systems.

If a country already has national health insurance, allowing separate insurance and discrimination in favor of its beneficiaries within public facilities may seem like the imposition of inequality into the system. If a country does not have national health insurance, creating the Australian model is an egalitarian move, even if not perfect. The politics then are entirely different. Substantive evaluations also depend on conditions. If a country is facing budget constraints yet wants to expand health insurance to all citizens, making the Australian choice — allowing private insurance as an alternative for some services — may make sense. The people who pay for private insurance may consume public services, but they are paying the same taxes as they would pay if they do not have private insurance, so to the extent that they choose to consume some services outside the public system, that may seem to free resources for other people.

In practice, the value of the tradeoffs from the Australian approach depend on variables that would vary greatly from country to country. I suspect, for example, that the fact that most of the hospital capacity of the nation was already in public hospitals guaranteed that Australian policy-makers would be more able to ensure adequacy of the public system and manage inequalities than if, instead, most of the hospital capacity had been in the private sphere. But that caveat itself demonstrates that variables that were not highlighted by the comparison between Canada and the United States, such as the share of hospital capacity that is owned by public authorities, are important. I have argued elsewhere that inequalities within the Australian system are reduced by the fact that much of the high-tech capacity is within the public hospitals, so physicians want to have admitting privileges in those hospitals, so even physicians who are in demand in the private tier of the system also are available in the public tier.²⁶² A country in which public authorities control the hospitals in which most doctors most want to practice is better able to risk creating a "two-tier" system of insurance than is a country that does not have that way of influencing physicians.

Even the lack of evidence that "managed care" controls costs better than Canadian cost control methods, and the evidence that competition among insurance plans creates some perverse effects, should not be interpreted as meaning that "managed care" per se does not offer some advantages in some Latin contexts. These failures are in comparison to a country that has a coherent system of national health insurance. But what do you do if you do not have such a system, and cannot imagine having the political support and resources to create one?

That is the norm in Latin America. In many countries health care in fact is paid for by a mix of three systems: private insurance and out-of-pocket; public

bureaucracies; and "social security." Social security systems frequently are limited to workers who receive wages from which contributions can be deducted (and to varying extent the families of these workers).

These social security systems, then, have a place similar to that of sickness funds in early-twentieth century western Europe. They covered only a portion of the population. This population had income constraints, and how to limit the contributions was a serious concern. But this population also, in societies in which many people did not have insurance, offered a relatively secure income stream to pay for health care. It was entirely reasonable for some physicians to choose security through selectively contracting to serve this population for salaries rather than fees for service; and it was entirely reasonable that the income-constrained sickness fund population would accept that limitation on which facilities they used in order to control costs and guarantee care. Indeed, the unions that controlled the sickness funds may have seen further advantages from creating their own networks of caregivers with a sickness fund and union orientation. In any event, sickness funds commonly created salaried clinics to serve their members — analogues of the modern staff-model HMO.

These clinics declined not because they were an inferior method of delivering care, but because the physician organizations vehemently opposed them, and eventually succeeded in getting them banned or limited in return for organized physicians' support for growth of the insurance schemes.²⁶³ Once accustomed to free choice of physicians, the public in France or Germany or Holland or Belgium would have little interest in re-creating reliance on such clinics. But beneficiaries in the social security systems of Latin American may be in situations much more similar to that of workers in Germany in 1910 than Germany in 1990.

The logic of selective contracting does not require that contracts only take the form of salaried employment in clinics. Other forms, similar to America's looser networks, might also prove attractive to both the members of social security schemes and some physicians. Encouragement of selective contracting in the social security arena may or may not make sense for the health care system as a whole. But one can imagine why it would be pursued by managers of the social security systems, for their own sakes.

In practice, both values and organization are likely to create obstacles to selective contracting within the social security systems of Latin America. Those systems may in some cases be providing care to nonmembers, and governments may worry that selective contracting would inhibit some of these subsidies. Moreover, when funds are not divided up by firm or occupation, but instead each fund represents a very large part of the local market, selective contracting is much more problematic: it may have less political support because it more seriously threatens the livelihood of the excluded physicians. The prospects for selective contracting within the social security systems therefore depend on each system's place within that nation's overall health care finance arrangements. Yet that is a very different conclusion from what an analysis of Canada alone would suggest.

Viewing the same point from a different angle, we must ask whether, if the money to expand solidarity does not exist, and fiscal pressures threaten care even for those people who are supposedly covered already, selective contracting on behalf of those systems is, in a practical sense, a threat to solidarity. If a system of exclusive arrangements helps both them and some providers to get by, and in other circumstances the vagaries of market and government would threaten both coverage and provider incomes, selective contracting may look like a better idea than the alternatives. This, of course, is how the world may have looked to the union funds

that engaged in selective contracting in the early 1900s in Europe. Expanding coverage to other people was not their problem.

One more example may reinforce the argument that conclusions about policy instruments based on analyses of the United States and Canada may not be appropriate for Latin American countries, because underlying policy goals may be different. In both Canada and the United States, policy analysts assume that the major objective of capital investment policy should be to limit investments that otherwise would be excessive, and in some cases even to reduce capacity. From that perspective allowing free rein to entrepreneurs to invest in health care capacity makes no sense. They may just add excess capacity, and they are particularly likely to build in areas where patients have more ability to pay, which are likely to be the areas that have least need of new facilities.

One has to wonder, though, how much sense these concerns make in countries where capacity is clearly much less than one would wish. Policymakers have good reason to resist physical investments that would distort policymakers' own operating budgets. Equipment that a nation cannot afford to properly employ and maintain can only yield disappointment, and often a waste of resources due to ineffectual efforts to make use of the "windfall." Policymakers in poorer countries also have to worry that private investments in facilities designed to sell to richer people may divert other supplies, such as physician services, from poorer people. Yet the choices are not cut-and-dried. Before universal coverage was created in Europe and North America, it was common for hospitals to provide a certain amount of "free care" to public charges. The question is not whether private investment is good or bad, but under what conditions governments can force contracts that direct enough services to public patients to make the investment a good deal for both private investors and the public. Governments may well be better off if they do not have to make such deals. But that is an easier position to maintain if you are in a rich country than a poorer one.

It is very hard to justify many common "market reforms" of health care finance based on experience in rich nations with universal health insurance.²⁶⁴ Yet, starting from different conditions or pursuing more limited goals, a greater role for private insurance or for private investments in physical capacity or selective contracting might be justified. The question is whether a particular policy that acknowledges and even formalizes inequalities might, nevertheless, be implemented in a way that improves conditions for less fortunate citizens. Such measures, which seem unnecessary and harmful in countries like the United States and Canada that could afford more solidaristic systems, may make much more sense in a country where the practical agenda is what kinds of substantial inequalities to accept.

4.3.- Conclusion

When comparing the United States and Canada, it is easy to assume that the goal of policy should be to provide health insurance to all citizens, at a not-ridiculous cost. The former is achieved in all nations of a comparable socioeconomic level except the US; the latter is a relative standard, but by any judgment the United State fails it, while Canada arguably could do better. In an ideal world all countries would be pursuing the same standard.

Whether that is the proper standard for evaluating health care reform in Latin America, however, is not so clear. It would be ideal. It may even be attainable (Costa

Rica may come pretty close). But it is obviously impossible in many countries, and would be exceedingly difficult in others — far more difficult, as a practical matter, than in the United States. As a political matter also, those who seek reform might not choose universal coverage as their goal.

In this conclusion, I have tried to summarize the lessons of the US/Canada comparison from both perspectives. Accordingly there are two bottom lines. The distinctive methods of American health care reforms are clearly inferior for the purposes of universal coverage at a reasonable cost. They may, however, have some applications for people who are pursuing different values, in a different context.

Endnotes for Conclusion

²⁶⁰ The International Bank for Reconstruction and Development, *World Development Report 1993: Investing in Health* (New York: Oxford University Press, 1993) pp. 116-23.

²⁶¹ See the discussion in Joseph White, *Competing Solutions: American Health Care Proposals and International Experience* (Washington: The Brookings Institution, 1995).

²⁶² This discussion follows the description in White, *Competing Solutions*.

²⁶³ See Brian Abel-Smith, "The Rise and Decline of the Early HMOs: Some International Experiences," *The Milbank Quarterly* 66:4, 1988, pp. 694-719. For the authoritative account of the evolution of European sickness funds, see William A. Glaser, *Health Insurance in Practice* (San Francisco: Jossey-Bass, 1991). This may be the single most useful book in English about health insurance.

²⁶⁴ The exceptions are best described in Richard B. Saltman, "The Role of Competitive Incentives in Recent Reforms of Northern European Health Systems" in Monique Jerome-Forget, Joseph White, and Joshua M. Wiener eds., *Health Care Reform Through Internal Markets: Experience and Proposals* (Montreal and Washington: IRPP and Brookings, 1995). As the discussion in this chapter of the British case suggests, "internal market" reforms applied to a system of direct provision of services, as opposed to marketization of insurance, does have some merits.

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