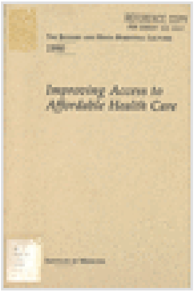

Improving Access to Affordable Health Care (1990)

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Institute of Medicine

THE RICHARD AND HINDA ROSENTHAL LECTURES
1990

Improving Access to Affordable Health Care

INSTITUTE OF MEDICINE

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions for the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 congressional charter responsibility to be an adviser to the federal government and its own initiative in identifying issues of medical care, research, and education.

Foreword

In 1988 an exciting and important new program was launched at the Institute of Medicine. Through the generosity of the Richard and Hinda Rosenthal Foundation, a five-year lecture series was established to bring to greater attention some of the critical health policy issues facing our nation today. Each year a subject of particular relevance is addressed through three lectures presented by experts in the field. The lectures are published at a later date for dissemination to a broader national audience.

In just two short years, this activity has won broad recognition and support. We have been privileged to have as speakers the leading spokespersons on the subjects under discussion. We have been pleased to have in our audience many of the key policy leaders and decision makers with major responsibility for making our health care system more effective and humane. In each case, the lectures and their associated remarks have engendered lively and productive dialogue.

The lectures and commentary in this volume address an issue currently receiving wide attention: improving access to affordable health care. Last year's Rosenthal lectures looked at the role of the federal, state, and private sectors in enhancing access to needed health care services. This year the series highlighted programs and demonstrations that might serve as models for a national reform agenda.

I would like to give special thanks to Karen Davis for moderating the 1989–1990 lectures. In addition, I would like to express my appreciation to Marion Ein Lewin for directing the Rosenthal program at the Institute and to her assistant Peg Dawson for ably handling the logistics associated with this endeavor. No foreword to this book would be complete, however, without a special expression of gratitude to Richard and Hinda Rosenthal for making this valuable and important effort possible. Clearly, no single speech or evening's presentations can resolve issues of great policy and political complexity. But it is fair to say that the Rosenthal Lectures are making a real contribution to defining the problems that need to be addressed and illuminating our search for productive forward strategies.

Samuel O. Thier
President
Institute of Medicine

Introduction and Overview

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Karen Davis

The United States health care system is increasingly the subject of critical reexamination and calls for major reform. After the United States pursued a policy of promoting access to health care services in the 1960s and 1970s, the emphasis shifted to curbing rising health care costs in the 1980s. Many have come to feel that the United States fails to achieve either objective—leaving millions of Americans without health insurance coverage, yet spending far more than any other industrialized nation on health care.

As the nation enters a new decade and nears the beginning of a new century, it is an important time of reassessment for national health policy. This year marked the release of several government and private sector reports calling for major reform of the nation's system of financing health care. In March 1990 the Bipartisan Commission on Comprehensive Health Care Reform (the Pepper Commission) issued a report outlining a mixed public-private universal health insurance system that would be phased in over a five-year period. Two major Executive Branch studies of the health care system are currently under way. The American Medical Association, the American College of Physicians, several other medical specialty groups, and a coalition of business and labor groups also issued major reports. This activity reflects the increasing seriousness of the problem of access to health care as well as widespread and growing public dissatisfaction with the performance of the health care system.

As a result, there is a new interest in the United States in learning from the experience of health systems in other countries. In part this interest is stimulated by new information and data contrasting the performance of the United States health care system with that of other industrialized nations. In part it is a reflection of growing discontent with rapidly rising health expenditures coupled with persistent gaps in health insurance coverage and barriers to access to health care. More fundamentally, it is linked to growing uneasiness about the future of the United States economy and its ability to maintain international competitiveness and a standard of living that has been the highest in the world.

This new interest in international experience does not mean that the United States is likely to adopt the health care system of any other country in total. Instead, the United States is likely to continue to evolve its health care system based on the historical, political, cultural, and economic forces that have shaped it in the past. Investigation of the merits of other systems, however, can identify features that show promise of being incorporated in the United States health care system.

Recent reports from the Organization for Economic Cooperation and Development have demonstrated that the United States has higher expenditures as a percent of gross domestic product (GDP) than any other industrialized nation. The share of GDP devoted to health care is 40 percent higher than in Canada, the next closest country. Further, the higher share of economic resources devoted to the health care sector cannot be totally explained by the greater prosperity of the United States and the tendency of countries to devote disproportionately more resources to health care as per capita income grows. Perhaps even more disturbing is the fact that health care spending continues to increase as a share of GDP in the United States, whereas it stabilized during the 1980s in other industrialized nations. Despite the commitment of substantial resources, the United States is among the worst of industrialized nations in infant mortality, life expectancy, and other measures of health outcomes.

Growing evidence of the comparative costliness of the United States system in the face of declining health performance in some areas strikes at a number of widely held beliefs. It has been argued in the United States that universal health insurance coverage, while desirable on humane grounds, is too costly and would be inherently inflationary. The ability of nearly all other industrialized nations to cover their entire populations for basic health services while devoting a smaller fraction of GDP to health care counters this view rather forcefully.

The better health performance of Canada and the European countries also strikes at the view widely held in the United States that the United States health care system is the best in the world. The failure of the United States to insure 15 to 20 percent of the population, the inadequate care provided to many disadvantaged groups, and the serious financial burdens inflicted on those unfortunate enough to have a serious illness and inadequate health insurance coverage are increasingly troubling to Americans.

The absence of federal health policy leadership in instituting comprehensive health care reform has resulted in a shift of responsibility to state and local governments. Many states have concluded that they can no longer wait for federal legislation to address the problem of deteriorating access to health care services and have instituted their own plans.

Many state and local government initiatives have been targeted on low-income people. In the 1980s, states have made major expansions in Medicaid eligibility for low-income pregnant women, children, the elderly, and disabled people—typically with federal matching funds, but on occasion with 100 percent state funds for low-income people not currently eligible under federal legislation. States such as Maryland, New Jersey, and New York have established uncompensated care pools under state hospital rate-setting programs to compensate hospitals for charity care. Florida and South Carolina have instituted indigent care pools financed in part by taxes on hospitals. Other states such as Texas have required counties to provide a minimum level of charity care, either through public hospitals or through payments to private hospitals for care of the indigent.

Hawaii and Massachusetts have become the first states to adopt universal health insurance coverage for all state residents. Hawaii first mandated that employers provide health insurance coverage to workers in 1974. In 1990 the remaining uninsured not covered by employer plans or public programs such as Medicare or Medicaid became eligible for primary care health insurance coverage under the Hawaii State Health Insurance Plan. Massachusetts also adopted legislation to provide for universal health insurance coverage by January 1992 under a mixed public-private system of health insurance coverage. Under the Massachusetts plan, employers with more than five employees would be required to either pay a payroll tax on earnings or provide minimum health insurance to workers and dependents. Those falling outside employer plans would be covered by a combination of premiums and state funds.

The Robert Wood Johnson Foundation's Health Care for the Uninsured Program (HCUP) has encouraged partnerships among employers, workers, and state governments in a demonstration to make health insurance more affordable for small businesses. Projects in states such as Maine and Michigan split the cost of employer health insurance among employers, workers, and state government subsidies. Some plans (there is one in Colorado) reduce the cost of the coverage by obtaining discounts from providers and instituting managed care alternatives.

One of the most controversial proposals has been one by the state of Oregon to establish a commission of private citizens to rank health care services from most beneficial per dollar spent to least beneficial in relation to cost. This ranking would be used to set priorities for funding health services to the poor under Medicaid. Monies saved from eliminating low-benefit services would be redeployed to cover uninsured poor people and to expand coverage for high-benefit services such as prenatal care and well-baby care. This proposal must receive a federal waiver in that it violates existing federal law prohibiting the limitation of Medicaid benefits on the basis of patient diagnosis or condition. However, it has appealed to a number of states grappling with approaches to rationing limited public resources for health programs.

Which of these directions holds promise for the nation? An answer cannot be long postponed. Health care costs continue to rise, absorbing an ever-increasing share of the nation's economic resources and raising concerns about our international competitiveness and the ability of our citizens and taxpayers to afford care. Further, we are faced with clear evidence of a deterioration in access to health care in the 1980s—robbing many Americans of an opportunity for a long and healthy life. Action must come soon. We are fortunate, however, to have an opportunity to learn from many who have already instituted universal systems of assuring access to health care.

In light of the tremendous divergence of experience with approaches to assuring universal access to health care both internationally and within the United States, the Institute of Medicine as part of its 1989–1990 Richard and Hinda Rosenthal Lecture Series invited speakers who are highly experienced and knowledgeable about not only the issue of access to care but also the experience of alternative approaches tried in specific settings. Participants in the seminar series met on three occasions to learn of these experiences. Each of the three major speakers—Robert G. Evans of the University of British Columbia speaking on the Canadian health system, Henry G. Cisneros speaking on local government approaches in San Antonio, Texas, and John A. Kitzhaber, M.D., speaking on the Oregon Medicaid plan—presented information on what has been tried and how it is working. Their remarks were followed by extensive discussion from a respondent drawn from a different perspective for the purpose of raising questions and suggesting alternatives. These respondents included William L. Roper, M.D., deputy assistant to the president for domestic policy and director of the White House Office of Policy Development;* Molly Joel Coye, M.D., commissioner of health for the state of New Jersey;† and Kenneth W. Kizer, M.D., director of California's Department of Health Services.

The hope of the Rosenthal family and the Institute of Medicine was that the many invited participants in this seminar series and the readers of the published lectures would be informed about the opportunities and limitations of alternative directions for resolving our nation's problem of providing greater access to health care. In that spirit, the Institute of Medicine is pleased to make available the remarks of these distinguished speakers and discussants. It is hoped that, collectively, they will provide information and guidance to Americans contemplating their response to these very important issues.

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*Dr. Roper is currently director of the Centers for Disease Control.

†Dr. Coye is currently associate professor and head of the Division of Public Health, Johns Hopkins University School of Hygiene and Public Health.

Accessible, Acceptable, and Affordable: Financing Health Care in Canada

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Robert G. Evans

THE MOST POPULAR PUBLIC PROGRAM IN CANADA

In the fall of 1988 there was a federal election in Canada, and the principal issue of debate during a very lively campaign was the upcoming free trade agreement with the United States. This agreement was viewed as much more than a commercial treaty with our largest trading partner. It was feared as potentially leading to a fundamental change in our whole sense of national identity, which has always been powerfully affected by our relationship (close but not *too* close) with the overwhelming presence of the United States. The Progressive Conservative government was committed to signing the agreement and was reelected on that platform, though with well short of a majority of the popular vote.

The government came very close to defeat, however, during a remarkable three-day period in the middle of the campaign in which the free trade issue became entangled with the health care funding issue. The opposition parties began to attack the agreement on the grounds that it would lead to the destruction of the Canadian health insurance system and its replacement with something more similar

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to the American approach. The public responded to this prospect with a massive swing against the government, almost overnight, of about 10 to 15 percent in the opinion polls. The opposition Liberals emerged in front. A desperate political damage-control exercise by the government convinced enough of the electorate that there was in fact no connection between free trade and health insurance, and the "tidal wave" slowly receded.

It is hard to think of a more reliable indicator of the extent and intensity of public support for the Canadian system of health care funding. Any government that was widely perceived to be putting that system at risk would become an ex-government at the next opportunity. No one imagines that the system is perfect; it has been surrounded by political controversy since its beginnings and is likely to remain so. But that controversy does not extend to the fundamental principles; after more than 20 years of experience, universal Medicare has a broader and firmer base of support than any other Canadian institution. There is no serious political voice calling for abandonment or major change, and the 1988 election reemphasized why.

But the extraordinary level of interest in the Canadian health insurance system which has recently appeared in the United States suggests that our concerns may have been misplaced. We feared that Americans would regard the Canadian system as an unfair advantage for our firms in the international marketplace and would demand that it be dismantled as a condition of the free trade agreement, to ensure a "level playing field." It did not occur to us that the United States might instead want to trade health care systems! (If we were to do so, of course, we would be very foolish to trade at par. We ought to charge quite a healthy premium.)

The massive popular support within Canada for our form of health insurance is a political fact, and its relevance to Americans is simply that those who live in the system overwhelmingly approve of it. It meets the tests of public opinion and political support. That might not necessarily be a recommendation—Canadians might be wrong, or might simply not know what they are missing. After all, it appears that citizens in most industrialized countries are strongly attached to their particular health care systems, just as they are to their individual physicians. The common American rhetoric, that whatever its problems, the American health care system is still the finest in the world, presumably implies that Canadians are misinformed.[1]

But it is relevant, I think, to note that Canadians are comparatively well informed about matters American, for reasons of simple proximity and relative size. Few Canadians are out of range of American television, most have traveled in the United States, and all are immersed in North American culture. They do have a picture of American health care which, if not complete (much less completely accurate—who has that?), is nevertheless likely to be a good bit clearer than the typical American picture of Canadian health care. And they know, very firmly, that they do not like what they see.

On the other side of the border, a substantial majority of a randomly selected poll of Americans expressed a preference for a Canadian-style system—at least as briefly described to them. This finding appears wholly unprecedented in international comparisons (Blendon, 1989). Again, those polled may be wrong, in the sense that if most Americans really had to live with such a system, they would be much less satisfied. But the ineluctable fact—and it appears to be a fact—is that Americans are not happy with what they have (Taylor, 1990).[2] Canadians are.

AFFORDABILITY AND ACCESSIBILITY: DEFINED HOW? JUDGED BY WHOM?

The design of health policy, however, is not judged solely by comparative popularity polls. Analysts and commentators look for objective facts (although they neglect at their peril the reality that to their political masters public opinion *is* fact). Ideally one would like to know what contribution different systems make to the health of the populations they serve. The true tests of a good system would then be "Does it work?" as well as "Does the population like it?"[3] The test of an innovation would be its potential for improvement on some combination of these measures.

Outcome data being notoriously inadequate at the individual level, let alone for entire populations, we fall back upon such intermediate measures as "affordability" and "accessibility." These have been of particular concern to Americans, because the various health care funding systems operating in the United States make up a package unique among industrialized countries, both in the level and rate of escalation of their costs (Schieber and Poullier, 1989) and in the proportion of the American population that has either grossly inadequate or simply no public or private health insurance (Short et al., 1988). Canada, along with all the countries of Western Europe, has achieved the combination of lower and less rapidly escalating costs and broader population coverage that most Americans appear to regard as proximate but perhaps (for them) unattainable goals.

Such goals, it should be noted, are in this context characteristics of a health care funding *system*, aggregating the experience of individuals and organizations. An individual with severe health problems and limited personal resources or insurance coverage might find care inaccessible because it was unaffordable for him or her. But the affordability of the system refers to its overall costs relative to the resources and priorities of the society as a whole. Whether or not the American health care system is in some sense "unaffordable" for the United States is a separate issue from whether needed care is "unaffordable" for some Americans or for their employers; either could be true without the other.

Of particular importance, because frequently a source of confusion, is that the costs of a system do not become more or less affordable by being transferred from public to private budgets, or back again. At the end of the day, the people of a country pay for the costs of their own care, and it is the total that matters. The total costs of health care do not become less of a burden on American society, or more affordable, simply because a substantially lower proportion of these costs is funded through public budgets than in other countries.

Similarly the accessibility of a health care system reflects the overall response of that system to the needs of the population it is intended to serve, and may be impeded by a variety of different barriers of which out-of-pocket costs are only the most easily identified.

There is, however, a danger that these intermediate criteria may be interpreted as more "objective" or more readily measurable (more "scientific") than the ultimate goals of positive health effect and public satisfaction. Certainly one *can* measure such indicators of cost and use as dollars spent, prices, number of treatments, persons enrolled, terms of coverage, and the like, and in principle with great precision. But terms such as "affordability" or "accessibility of care" go well beyond measurement and embody implicit values and choices—judgments—that cannot be derived from the data themselves.

What is affordable depends on one's preferences and priorities as well as on costs; very rarely are wealthy societies constrained in any particular endeavor by absolute shortages of resources. But the setting of social priorities is quintessentially political, not "scientific." The "expert," medical or economic, has an important task in trying to lay out the options as accurately and honestly as possible. But the actual setting of priorities, the making of choices, is the role of the citizen and voter. The expert qua expert is no better equipped than anyone else for this task and is entitled to only one vote.[4]

Similarly, the issue of accessibility begs the question of what is to be accessible, to whom, and under what circumstances? Accessibility per se is really a means to one or more ends, not an end in itself. The end that is sought through health care is health, and the accessibility of health care is valued principally on the belief that such care will contribute to someone's health.[5]

The connection between health care and health is, however, highly uncertain and contentious; students of the effectiveness of health care emphasize that most of it is at best unevaluated and that even interventions that are demonstrably effective in specific circumstances are very widely misapplied (Banta et al., 1981; Feeny et al., 1986). It follows that accessibility as a normative concept, a proximate objective, cannot be identified or compared across systems simply on the basis of a set of measurements of utilization. One needs to know what forms of care are being provided or denied to persons in particular circumstances, in order to determine whether differences in access to care correspond in any systematic way to differences in access to health. Better access to useless or harmful care is not in general a cause for congratulation.

But useless for what? Such a statement presumes an unambiguous and generally agreed upon concept of health against which interventions can be evaluated. For some aspects of health this is a reasonable approximation, but other dimensions are highly debatable and culture dependent. There will be disagreement among individuals and particularly across cultures as to the nature and extent of the "health" that accessibility to care may promote. The meaning and the value of "accessibility" to particular states as well as services will then also vary.

Nor is this only an abstract possibility. The individual undergoing regular monitoring of his serum cholesterol level, and on a strict dietary and drug regimen for life, may be regarded by one person as healthy because his probability of death from heart disease is reduced. But another may see the same individual as sick, because he is now both physically and psychologically dependent on care—morbidly concerned with his own health. Should a "good" system promote, or even provide, universal access to cholesterol screening? Hume's Law applies: one cannot derive "ought" from "is." And words like "affordable" or "accessible" are inherently "ought" words, laden with normative content. What ought particular people to receive? And how much should they or others be willing to pay for this?

With this caveat, we shall sketch out some of the basic facts and central features of the Canadian health insurance system, noting particularly the principal similarities with and differences from the forms of funding in the United States. Structural differences then lead into differences in performance, although the connection provides fertile ground for interpretation and disagreement over precisely why things have evolved differently on each side of the border—or for that matter how different the systems really are.

Differences in performance are then matters for evaluation, and we will consider some of the problems of interpretation that arise in moving from "cost" to "affordability" and from "coverage" to "accessibility." These problems are not insurmountable, but they do involve certain unavoidable value judgments that provide a context for the choices inherent in any process of health care funding. Subject to this qualification, however, it does appear that the Canadian system of health care finance is both more accessible and more affordable than that of the United States and that its advantage is growing over time. The two populations are not wrong in their respective evaluations of their systems.

HEALTH CARE FUNDING IN CANADA

The "stylized facts" of health care funding in Canada, stripped of a multitude of fascinating but inessential footnotes, are as follows. Canada does not have "socialized medicine," but it does have socialized insurance for hospital care and physicians' services. Each of the ten provinces operates a payment system that reimburses private fee-for-service physicians for the care they provide to their patients, according to a uniform fee schedule negotiated at periodic intervals between the provincial medical association and the provincial government. The schedules differ across provinces. Physicians have admitting privileges in hospitals run by community or municipal boards; these hospitals derive their operating funding from annual global budgets negotiated with the provincial ministries of health.

The costs of this system are met by each province out of its general tax revenue. But the federal government also makes a substantial contribution to the provinces, currently about 40 percent on average of program costs, in the form of a block grant rather than as a share of audited costs. The federal government requires that the provincial plans meet certain conditions to be eligible for these funds, hence the close similarity among provincial plans despite their technical independence.

In particular, the provincial plans must cover 100 percent of their populations, for all "medically necessary" services. This is significant in those two provinces that still require their residents to pay premiums for health care. (The revenue from these premiums is not earmarked specifically for health care, but is in effect pooled with general provincial revenues.) One cannot be denied services for failure to pay premiums; such "premiums," which are also unrelated to risk status, are in fact a form of poll tax. (Most people do not, however, know that they cannot be denied care, and provincial governments do not try to disseminate the information.)

Furthermore, while the federal conditions do not ban charges to patients, they do provide that a province's grant must be reduced by any amount the province charges, or permits to be charged, to patients for insured services. In response to this, provinces have in various ways discouraged physicians from extra-billing patients in amounts above the provincial fee schedule, and do not impose charges for hospital services. (Patients in long-term care institutions, however, are charged a daily rate calculated to recoup most of the public minimum pension. And patients in acute care, who in the judgment of their physicians do not require semi-private or private room care, may nevertheless choose such care on payment of a "preferred accommodation differential." If medically required, of course, such care is free.)

Accordingly, all residents of Canada are fully insured for all "medically necessary" hospital and medical services.[6] Access is universal and complete, in the sense that there are no financial barriers to care. While it is clear that this does not exhaust the possible content of "accessibilty," it does mean that the phenomena of medical indigence and bankruptcy, uncompensated care, patient dumping, and other forms of financial discrimination simply do not exist. The anxiety and distress suffered by so many individual Americans as they contemplate the potential or actual impact of ill health on their economic situation, has no counterpart in Canada, while those responsible for managing or paying for the system do not have to cope with the problems and costs raised by the multiplicity of maneuvers to pass costs on to someone else.

UNIVERSALITY IS CHEAPER: A PARADOX, BUT A SMALL ONE

Nor is it the case, as so often claimed in the United States, that universality implies national bankruptcy, or even "unaffordability." The assumption that there is an inevitable trade-off between accessibility and affordability is one of the more deceptive and disabling fallacies injected into public debate, often by economists suffering from a bad case of "a priorism" and a low level of comparative information.

The fact is that Canadians spend substantially less of their national income on health care than do Americans, about one dollar in twelve compared with nearly one dollar in eight south of the border.

In proportionate terms, this amounts to a saving of about one-quarter. And all of this difference is in the total costs of hospital and medical care services (those components of national health expenditure covered under the universal public Medicare program) and in the overhead costs of the insurance programs themselves. Such items as dentistry, out-of-hospital drugs, and public health are not covered by that program, and their costs do not in total differ very much from south to north (Barer and Evans, 1986; Evans, 1986).

The Canada-United States divergence, which now amounts to two percentage points of gross national product (GNP), or in American terms about $100 billion, has emerged in the two decades since the Canadian system was fully established. The last province entered Medicare on January 1, 1971; in that year both Canada and the United States spent roughly equal shares of their national income on health care. Furthermore, the pattern of cost escalation in the two countries had been virtually identical over the previous 20 years. Between 1971 and 1987 the health spending share in the United States rose further, from 7.6 percent of GNP to 11.1 percent, while the corresponding Canadian increase was from 7.4 percent to 9.0 percent. And virtually all the Canadian increase occurred in one year of deep general recession—1982—when real national income fell sharply (Health and Welfare Canada, 1987; Levit et al., 1989; unpublished data from Health and Welfare Canada, 1989).

The Canadian experience thus demonstrates that, far from being in conflict, affordability and accessibility are complementary goals. It is the universal system, channeling all reimbursement through a single payer, which has made both possible. More detailed analysis of the functioning of the health care systems on both sides of the border confirms this view.

As further evidence, most countries in Western Europe have, since 1980, stabilized the growth of their health care sectors to a roughly constant share of national income. All have universal, public, or quasi-public health insurance programs. Sweden and Denmark have actually significantly reduced the share of health spending, from 9.5 percent and 6.8 percent of gross domestic product (GDP), respectively, in 1980, to 9.0 percent and 6.0 percent in 1987. Sweden began the decade with the highest share reported among the nations of the Organization for Economic Cooperation and Development (OECD); but in 1980 Denmark was already *below* average. For the OECD as a whole, the average share of national income spent on health has moved from 7.0 percent of GDP in 1980 to 7.3 percent in 1987; however, this average includes the United States (Schieber and Poullier, 1989). Canada is no longer unique, although we do have the longest record of cost control.

But the total costs of health care in any country are also by definition the total incomes earned from the provision of health care. This elementary mathematical identity is extremely important to the understanding of the air of continuous controversy surrounding the system that I have portrayed as affordable, accessible, and overwhelmingly popular with the citizenry of Canada. That controversy, which is real, long-term, and likely to continue indefinitely, may mislead some external observers (and even some internal observers) into wondering if the system is collapsing.

Hospital and medical care is "free" to the user, but of course not to the society as a whole. And while the overall cost is much lower than in the United States, the fact that provincial treasuries bear all of that cost places them in continuing conflict with the physicians, nurses, hospitals, and other providers of health care for whom no amount of spending is ever quite enough. Funding health care is the largest and most politically volatile responsibility of any provincial government, with the greatest political dangers. Precisely because the controls on spending work, the payment systems are a lightning rod for professional dissatisfaction. As a group, providers have learned to live with cost control; but they have never accepted it in principle, and it would be naive to imagine that they ever will.

This inherent conflict of interest between payers and providers is common to all financing systems. And the fact that a sense of financial "crisis" is observed in so many national systems, at very different levels of funding in both absolute and relative terms, suggests that controversy is the result, not of spending levels per se, but of any attempts to contain cost growth, regardless of the level of spending. Controversy is the price of affordability (Tuohy, 1986; Evans et al., 1989b; Evans, in press; Evans, 1990). As the American example shows, the price must be paid even for unsuccessful efforts at control.

It would be quite wrong to conclude, as the American media tend to do, that every funding system has problems and therefore all are in the same boat. While all struggle with the same problems, some struggle much more successfully than others. Moreover the costs of the struggle are borne very differently. In Canada, providers and payers fight; patients are in the audience. In the United States, the patient (or the employer) is down in the ring struggling with providers, and it is a much less equal contest.

It does not follow, of course, that the Canadian system is ideal and that Americans should immediately try to import it. Each country has to develop a system of health care funding and delivery consistent with its own culture and history, and our histories and cultures are different. But if Americans really want to achieve operating results similar to Canada's, controlling overall costs and covering the whole population, then they will have to, in their own way, develop mechanisms for imposing the kinds of limitations that exist in Canada. The institutional features may be different, but they will have to accomplish the same objectives.

EVERYBODY IS DOING IT—CANADA IS JUST NEARER

This generalization is supported by the Western European experience. As noted above, the majority of developed countries have succeeded in stabilizing their health care costs as a share of national income. They have done so in very different funding systems, but all provide more or less universal coverage, either through a single payer or through a number of payers who are then coordinated by legislation and regulation. The coordinated payment system is then the mechanism through which various forms of controls are applied. The United States is now the outlier, the one country that has not succeeded in achieving stability. And the outstanding difference is that the United States is the one country that has not gone to some form of universal coverage (Abel-Smith, 1985).

The critical linkage seems to be between universal coverage and sole-source, single-payer funding. As noted, this may be achieved either by a single payer in fact, as in Canada or Sweden, or by multiple but legally coordinated payers, as in Germany, or by a handful of payers each with exclusive jurisdiction. One could certainly imagine a system of large numbers of uncoordinated payers which was extended (at least briefly) to provide universal coverage. This appears to be the solution advocated by the American Medical Association (AMA)—"universal access, not universal insurance"—to deal with the large number of uninsureds (Todd, 1989).

Such a system would generate even more rapid escalation of costs (i.e., provider incomes) than the present American system, while preserving both the financial and the clinical autonomy of providers and the impotence of payers. It would add more money to an already overinflated system and more bureaucratic overheads to run yet another program or programs. But once it has been decided that everyone is to be covered, the whole apparatus of private insurance (designed in a private marketplace to determine whom to cover, at what price, and whom to exclude) becomes a complete waste of motion. The higher cost and dynamic instability of such an approach make clear why, in practice, universal coverage is always associated with sole-source funding, de jure or de facto.

While universality of coverage and sole-source funding are, as far as we know now, preconditions for cost control, it also appears that cost control reinforces universality. The absence of control, in the American environment, creates strong incentives for those who bear the ever-increasing costs to try to pass them on to others. Governments and employers are thus tempted, if not forced, to increase the premiums charged to those covered, while cutting back on the scope of coverage by imposing larger copayments on users of care or by pushing people off their rolls. Contrary to the naive predictions of market economists, this has not been effective in mitigating the escalation of costs, but it does add significantly to the human cost of ill health by adding financial insult to health injury. When the lifeboat is leaking, one reaction is to throw people overboard rather than to try to plug the leak. The universality advocated by Todd (1989) would, if ever achieved, begin to crumble in this way almost immediately.

WHAT SEEMS TO BE THE PROBLEM, SAM?

We began the discussion of health care systems by defining a "good" system as one that makes a positive contribution to the health of the population it served and is popular with that population. We then promptly retreated to the intermediate and somewhat more measurable criteria of affordabiliity and accessibility. What has demonstrably been achieved in Canada and Western Europe, however, is cost control (at least relative to the United States) and the almost universal removal of financial barriers to health care utilization. As emphasized above, these are not necessarily equivalent to affordability and accessibility. The latter labels imply certain evaluative judgments on the desirability of the outcomes achieved, judgments that do not follow automatically.

There is no magic level of expenditure beyond which health care becomes "unaffordable." Americans can obviously "afford" to spend over 11.0 percent of their national income, unambiguously demonstrated by the fact that they are spending it now. A number of other countries—Canada, France, West Germany, the Netherlands—spend between 8.0 and 9.0 percent, and Sweden has moved down to this range since 1980. Britain, Australia, Denmark, and Japan, by contrast, spend much less on health care—between 6.0 and 7.0 percent of their national income—and they too worry about affordability.

Countries do not spend what they do as a result of some explicit decision that that level is "right," although Denmark and Sweden seem to have made fairly broad-based collective decisions to bring their spending down, in relative terms, in the 1980s. But for other countries, and Canada in particular, the current spending share is simply the share that our previously escalating costs had reached when we managed to develop both effective instruments of control and the political will to use them to put the lid on. After that, holding the lid on at any level requires constant political struggle with providers who are convinced that, whatever the level of spending, more would always be better.

One cannot necessarily assume that the level of spending is wholly arbitrary; different societies may have different spending propensities, and perhaps Canadians or Germans would not tolerate the health care system that they could buy for 6.0 percent of their aggregate incomes. But health spending in Canada, from 1971 to 1981, remained quite close to the 7.5 percent it had reached when the universal public insurance system was completed. It moved up sharply to the 8.5–9.0 percent range in 1982, *not* because payers or the rest of the community had accepted providers' arguments for more, but simply because in the recession of that year national income fell sharply. But the increase of one entire percentage point of national income in the early 1980s has made no difference whatever to the terms or the tone of the financing debate.

The United States is of course in the special situation of having both by far the world's highest costs and as yet no effective instruments of control. But as a matter of arithmetic, normal rates of economic growth would permit the United States to increase its share of income spent on health care for many more years (albeit slowly), and still have growing resources available for consumption or investment. So why should that country be particularly concerned over the "affordability" of health care?

A commonly expressed concern is that the cost of health care borne by American business is both heavy and growing rapidly, making American products too expensive to compete in international markets—or indeed at home. This is the point mentioned above, in reference to the Canada-United States free trade agreement, that our less expensive health care system gives Canadians an "unfair" advantage and that Americans might argue that Canadians should be forced to labor under the same handicaps that they have imposed on themselves.

On examination, however, this argument seems too simple. In the first place, a general cost disadvantage suffered by American firms can be compensated for through exchange rate adjustment. A decline in the value of the American dollar can offset a rise in health care premiums—if that is the source of competitive disadvantage.

But secondly, employer-paid health care premiums are part of the overall compensation package of labor, and it is that package, not any single component of it, which represents the cost of labor to the employer. If health care premiums are rising, why can that not be balanced by a less rapid rise, or indeed a fall, in money wages? After all, surely workers would realize that their total compensation is rising? If they prefer to take that increase primarily in the form of increasingly costly health benefits, why should that raise the employer's overall costs?

Yet each of these responses is itself as naive as it is obvious, suggesting that "affordability" runs somewhat deeper than a simple problem with labor costs. The weakness of the "currency devaluation" response (apart from the impact of devaluation on relative asset holdings), is that the growing burden of health care costs is very unevenly distributed among employers. It bears most heavily on long-established industries with mature work forces—older and retired workers whose health expenditures are highest. Newly established firms, in new or old industries, have a significant advantage. Thus a foreign producer of automobiles, for example, which sets up a plant in the United States can hire a younger work force and will have no obligations to retirees. It will therefore have a built-in cost advantage that no currency adjustment can touch.

The root of the problem is the employer-based financing system. Employers with older work forces and binding commitments to retirees must either accept a permanent cost disadvantage or try to push down the money wages of their workers as their health care costs increase. This in turn might be accomplished through lowering wages at all ages, resulting in their becoming less competitive in the market for younger workers, or through reversing the usual seniority system by paying workers less as they grow older and generate higher (expected) health care costs. None of these options is very attractive.[7]

In a Canadian-style system, by contrast, the increasing health costs of older workers, like those of all other older individuals, are spread over the community as a whole through the general tax system. The province of Quebec also raises part of its revenue from payroll taxes, and Ontario has announced its intention to follow suit, but the tax rates are invariant across employers. They do not impose a differential burden on particular firms or industries. Thus the Canadian advantage from a lower-cost system overall is accentuated in industries with mature work forces.

But what, apart from long-established industrial relations tradition (and the consequent probability of severe industrial unrest and associated costs), is wrong with reversing the seniority profile and paying older workers lower money wages as their health care insurance costs rise? This leads into the second point above, the "overall compensation package" argument. Older workers would not really be earning less, only taking their earnings in a different form.

Indeed this argument is more general. From the "total compensation" perspective, Americans collectively are not worse off as their health care costs escalate. They are simply taking their increased income—the dividend of economic growth—in the form of health benefits rather than as other types of consumption. Some analysts—economists mostly—have gone so far as to suggest that an empirical correlation between per capita national income and share of income spent on health care indicates that, contrary to the traditional interpretation, health care is a luxury good on which wealthier nations "choose" to spend relatively more.

Far from being a problem, increased health spending is on this view the natural consequence of growing wealth. As a subtext, other countries with lower spending levels are then not ahead of the United States in being more successful at control, but behind in that, when they are as wealthy, they will spend as much.[8] Furthermore, this interpretation also implies that the widespread American concern over the affordability of health costs is unjustified and presumably that all those who share it are simply misinformed or confused. Rather than wringing their hands, Americans should happily open their wallets and celebrate the increased well-being that health spending brings.

CAN'T PAY? WON'T PAY? DON'T WANT TO PAY! (AND CAN'T STOP PAYING)

Providers of care are in the main in enthusiastic agreement with this line of argument, but few other Americans seem impressed. Just as workers strongly resist accepting lower wages as their health premiums rise (hence the competitive disadvantage of their employers), so Americans in general seem by their behavior to have rejected the idea that their increased health spending is adequate compensation to induce them to give up other consumption. This could reflect a belief that additional health spending is not in fact yielding "value for money" but is being dissipated in higher provider incomes, overhead costs, and ineffective interventions. Alternatively, it may be that even "effective" care, which results in some form of health benefit, is no longer considered worth the price. This is in fact a perfectly reasonable position, for low enough benefits and high enough prices, but very few are willing openly to admit it.

Either way, the real source of distress is not that Americans cannot afford their health care but that they do not want to. The social priorities of the United States, and the private priorities of individual Americans, are in conflict with the amounts that are spent on health care. But the American institutional framework does not permit the balancing of health care against those other priorities, or generate effective pressures to promote "value for money." Instead it encourages or forces the expansion of health care, which is not valued as much as the other opportunities that are foregone in consequence. The absence of any mechanisms for the containment of overall costs, or for the more equitable distribution of those costs over the whole community, means that Americans remain unhappy with the overall result. If that is not what the concern for affordability means, it is hard to think of any other logical content that it might be given.

At the level of the individual firm, the result is that profitability and competitive advantage come to depend not just on the value of the product or the skill and effort of management and labor, but on the historical accident of the age and health status of the work force and the relative conservatism or extravagance of the local health care providers.

At the national level, the unwillingness of Americans collectively to forgo other consumption as their health care costs rise may be part of the explanation for the particularly anemic American savings rate, relative not only to that of Japan and other Pacific Rim countries but even to that of Canada. A difference of several percentage points of national income spent on health care—3.0 percent more than most other industrialized countries and 5.0 percent more than Japan—leaves room for a great difference in savings. Business spending on health benefits has risen from 14.4 percent of after-tax profits in 1965 to 94.2 percent in 1987 (Levit et al., 1989).

In summary, the American health care financing system seems most responsive to the priorities of providers of care, for whom ever-growing expenditures represent ever-growing incomes. The users of and payers for this care do not seem to value it as much; this is expressed both in their widespread complaints about "unaffordability" and in their resistance to reducing other forms of consumption to pay for this supposed benefit. Their resistance, in turn, may be part of the explanation (although the tentativeness of this part of the argument must be emphasized) for the decline in American savings rates, such that investment levels can only be maintained with increasing foreign borrowing. In this way the long-run growth of the American economy is mortgaged, in part to pay for the expansion of health care. Such a scenario can certainly be described as "unaffordability."

On the other hand, the shrill cries of "unaffordability" that arise regularly from governments and other payers for health care in all the other countries of the developed world are, ironically, part of the process of control. Since cost control is always and everywhere achieved in the teeth of the providers of care, who are constantly struggling (for quite understandable reasons) for expansion, it is necessary to mobilize a political constituency for control. This is done, not by arguing—in defiance of providers and usually patients as well—that more spending on care would not be a good idea, but only that the cost pressures are so severe that it is for the moment "unaffordable."

It is "unaffordable" in the United Kingdom, where 6.1 percent of national income is spent (Schieber and Poullier, 1989), or in Canada, where 8.6 percent is spent, or in the United States, where 11.2 percent is spent. The difference is that in most countries other than the United States there are institutional mechanisms capable of imposing control. The principal problem is the maintenance of political will, which in turn ultimately depends upon popular support or at least acquiescence.

"YOU DON'T WANT YOUR BABY TO DIE, DO YOU?" . . . DOCTOR KNOWS BEST

Across the political and rhetorical trenches from the advocates of affordability are the defenders of "accessibility"—a confrontation observed everywhere in the developed world. These are the beneficiaries—providers and to some extent patients—of increased expenditure. Outside the United States, universal financing systems have largely removed the issue of individual ability to pay for care; the arguments over access now turn on the adequacy of the total resources mobilized through the health care system, its capacity and level of output. All health care systems outside the United States are "underfunded" according to the official spokesmen of those who work in them; this includes in particular the Canadian system which, according to the OECD statisticians, is the second most expensive in the world. None, it is claimed, have sufficient resources to meet the needs of those for whom they are supposed to care.

The structure of the argument has become familiar, during 1989, to any American interested in health care. Defenders of the status quo in American medicine have responded to the increased interest in universal public funding, and particularly the Canadian example, by charging that the Canadian system fails grievously in meeting the needs of the Canadian population, or does so under conditions that would be unacceptable to most Americans. The process of cost control is alleged to result in long waiting lists and queues for care, unavailability of the most modern technology, depreciation of the physical plant, and a general deterioration of standards in a stagnant, bureaucratic, "public utility" style of medical care.

The apparent universal accessibility of health care in Canada is thus portrayed as a hollow boast; care may be "free" at the point of service, but the services are not really there when needed. Affordability has been gained, but at the cost of genuine accessibility; in this context financial accessibility is simply a sleight of hand. An air of artistic verisimilitude is then added by selected anecdotes of particular Canadian patients suffering, and perhaps even dying, as a result of care delayed or denied, or fleeing to the United States for the services their own country cannot or will not provide.

This argument draws on two powerful rhetorical traditions. First, it implies that everyone is out of step but Uncle Sam. All the countries of Western Europe also have public or quasi-public funding systems, covering all or almost all of their populations. And all have now succeeded in limiting the growth of costs to a proportion of their national income equal to or less than that in Canada. It follows that they must be "underfunding" their systems, and subjecting their populations to inadequate care, to an even greater degree than is Canada. This sort of argument, that American differentness implies American superiority, has always been popular in the United States. A foreigner such as myself can only ask, if Americans really are convinced that they have the world's finest health care system, or even an adequate one, why are so many of them so unhappy with the result?

Secondly, the underfunding/unmet needs argument follows very smoothly from an ancient medical tradition that can be expressed alternatively as "your money or your life." Only professionals are capable of determining how much and what kinds of care are needed by a population, and in the subtext only professionals should decide how much they themselves are entitled to be paid in the process.[9] The third-party payer, public or private, has no right to interfere in this process; its only legitimate function is to pay the bills. To the extent that it fails to do so, the patient should be required to make up the difference, but the overall size of the bill is a matter for professional judgment alone.

That professional judgment is, by definition, exercised only and wholly on the patient's behalf. It follows that any attempt to limit the flow of resources into health care must lead to harm to patients—needless suffering and perhaps even death. After all, if the care were not needed, professionals would not be recommending and providing it. And the price they demand for their services will be both fair and necessary to compensate for their effort, responsibility, and training. Again, one can rely on professional responsibility for that.

The argument is quite circular and is intended to be so. Since Canada is containing costs, relative to what American—and many Canadian—providers would demand, then a priori Canadian patients must be suffering as a result. Interestingly this circular argument has an exact parallel when naive neoclassical economic analysis is applied to the question, a parallel in which "the market" plays the central role that professionals assign to professional responsibility.

THE ECONOMIC VARIANT: DOCTOR PANGLOSS GOES TO MARKET

The economic argument begins from the accounting identity noted above, that total expenditure on health care necessarily equals total income earned from providing health care. If that total is reduced—or its growth restrained—it follows that either fewer goods and services must be provided or lower prices must be paid, on average, for them. But by hypothesis, the price of the services is a reflection of their "quality," that is, it is determined by the competitive marketplace. It follows that cost control reduces either the quantity or the quality of the care provided, or both, which is exactly what the AMA would—and does—say.

Both forms of analysis demonstrate "conclusively" that accessibility *must* be reduced, in either quantity or quality terms, as a consequence of cost control. Moreover, they do so on purely a priori grounds, in a totally data-free environment. (Actual information would be an irrelevant distraction.) The trick is worked, as in all a priori arguments, by careful choice of assumptions and definitions. In particular, both medical and economic arguments sidestep completely the question of outcomes or the effects of care on the health of patients.

Most people interested in health policy, most patients, most physicians, most of us, judge the quality and appropriateness of care by the likelihood that it will do more good than harm to someone's health. The Canada Health Act, which lays out the conditions that provincial health insurance plans must meet to be eligible for federal financial contributions, explicitly states that the purpose of the system is to maintain and improve the health status of the population.

Accessibility is then judged in terms of whether people can in fact get the care that they need, in the sense of care that is likely to improve their health. And accessibility of higher-cost care is only worthwhile if that higher cost purchases higher expectation of benefit. How much higher? That is a touchy policy judgment. But most of us can agree that there had better be *some* extra benefit.

On the other hand, the a priori arguments, both professional and economic, carefully avoid explicit consideration of this issue. The first imposes the assumption that whatever is provided must have been needed, otherwise expert and responsible professionals would not have provided it. The second modifies this to the assumption that "consumers" of care (not patients) will use only those services that they value and that their valuations, not health outcomes, are the legitimate standard against which to judge accessibility.

As an aside, by this argument the American health care system must be faulted for making access to laetrile, or quack remedies generally, more difficult, because a number of "consumers" obviously want to buy them. It cannot be faulted, however, for failing to provide care to those "unwilling" to pay for it. That is right and proper, because they obviously do not value care sufficiently to justify its cost of provision. That their unwillingness may be rooted in absence of insurance or personal resources is irrelevant.

This is not merely a debating point. "Consumer" willingness to pay, unadjusted for differential resources or imperfect information, is by assumption the fundamental test of value in the intellectual framework of market economics. It is the foundation stone on which are based all normative statements, all policy recommendations as to what "should" be done. The well-organized economy provides whatever people want—if they have the resources to pay—and does not provide commodities for which they will not or cannot pay. The full implications of this assumption are rarely highlighted by neoclassical economists. But the advocate of "free market" approaches to health care delivery and finance, who does not simultaneously advocate open access to "quack" practitioners and remedies of all kinds, is simply being intellectually inconsistent. In the free market there are no quacks; the concept has no meaning.

It is important to be clear about the fundamentally circular nature of such critiques of the Canadian health care system, since otherwise a good deal of time and energy can be wasted in discussions that by design go nowhere. But the question of the accessibility of needed care in different funding systems remains a very serious one, quite apart from its misuse in public relations exercises. Americans know full well that a substantial proportion of their population has access to either substandard or no care, as a result of economic barriers. But it is certainly possible, though not self-evident, that the accessibility that the Canadian funding system gives with one hand, by removing financial barriers, it takes away with the other, by providing insufficient resources to meet population needs.

THE PRICE OF PAYING LESS: WHAT DO CANADIANS GIVE UP?

It was suggested above that the tests of a health care system were its contribution to the health of the population it serves and its acceptability to that population. Does it work, and do they like it? Both are linked to accessibility. If a system is "underfunded" in a real sense, not just in that the people working in it would like higher incomes and more gadgets to play with, then the resulting restriction of access should be visible in either adverse health outcomes—mortality and morbidity—or increased time and trouble for patients in gaining access to care, or both. Health status and public satisfaction should suffer.

One could add a third criterion: the degree of equity of access within the health care system. Some, myself included, believe that a good health care system provides care on the basis of need rather than ability to pay and treats all members of society equally in this respect. All systems "ration" care, in the obvious sense of the elementary economics textbooks. But a system that denies or impedes access for those with greater needs and lesser resources, while responding with alacrity and enthusiasm to those with minimal or imaginary needs but ample resources, is on this criterion significantly inferior, in terms of accessibility, to one in which all citizens with equivalent needs are treated (more or less) equally, even if the latter system does not meet all needs that providers can imagine and communicate to their patients. Nor is this inferiority compensated for by a higher level of provision overall; inequitable access is not mitigated by providing even more services to those who do not need them.

It is not, however, appropriate to insist on this criterion in the present discussion. In the first place, it is probably not as widely shared, particularly in the United States, as the first two. (Although it may be more widely shared, even in the United States, than is reflected in current practice; why else would the existence of so many uninsureds and underinsureds be the occasion for such public handwringing, even by those who have no intention of doing anything about the situation? [See Taylor, 1990.]) And secondly, such a criterion rigs any comparison with Canada so heavily against the United States as to amount to settling the accessibility issue a priori, a strategem that was just criticized above.

Despite the political controversy that forever surrounds health care funding in Canada, the popular support for that system remains, as noted at the outset, overwhelming. Moreover, that support has been demonstrated in the most unambiguous fashion possible; it is not merely inferred from the conversations of visiting academics with taxi drivers. But that still leaves open the second question: "Does it work?" Or does universal public funding with cost containment result in impeded access to needed care and consequent adverse outcomes?

Ideally, we would wish to be able to measure the patterns of morbidity and mortality in Canada and the United States and attribute them to the contributions of the respective health care systems. We would then be able to determine, for example, whether the fact (if it is a fact) that the United States has more CT scanners than 7-Eleven stores, and Canada does not, pays off, all else equal, in greater health for Americans. Those who argue that the Canadian system is "underfunded" are implicitly asserting that this is the case. Unfortunately, they do not have the evidence to support this claim. Nor do I, and nor does anyone else.

It is notorious, throughout North America and Western Europe, that minimal data are available on the health status of populations, let alone on the relationship between that health status and the provision of health care. Mortality data are available but, as everyone knows, there is much more to health than life alone, and, anyway, many other factors affect mortality. The rather idiosyncratic approach that Americans take to gun control, for example, clearly has a bearing on their relative mortality statistics. Indeed, the country that is currently showing both the best and the most rapidly improving life expectancy statistics, at all ages, is Japan. Its health care system has recently been described by a respected external observer as "anachronistic" (Iglehart, 1988), and the OECD statisticians report that Japan spends a bit more than half as much as the United States on health care, relative to its total income.

For what it is worth, the comparative data available on mortality and morbidity in North America show Canadians as slightly healthier than Americans, but very little different (Battista et al., 1986). There is no necessary connection with the effectiveness of our respective health care systems. One can certainly say that there is no indication, at the aggregate level, that the health of Canadians has been affected as a result of our spending less on health care. Whether Americans are beginning to see, in their infant mortality and life expectancy trends, the consequences of unequal access to care is another matter, but fortunately not one that need be dealt with here.

While it may be impossible to assess directly the relative health contributions of entire delivery systems, clinical epidemiologists make their livings carrying out such investigations on particular diagnostic and therapeutic maneuvers. They very commonly find that such interventions, offered in good faith and carried out competently, turn out to do no good, and sometimes even harm, to some or all of those who receive them. Accordingly, there is no a priori reason to assume that less care, in total, implies less health—Canada may simply provide less ineffective care. But then again, it might not.

One can, however, get at the accessibility question indirectly and produce a partial answer that goes a good deal of the way by examining just what it is that Canadians spend less on. If it could be shown that the difference in overall spending were accounted for by items that have no direct connection with health outcomes, that would support the inference that accessibility was not in fact being impaired in Canada. As it happens, not all but most of the difference *is* accounted for by such items.

The discrepancy between health spending in Canada and in the United States can be measured in several different ways, but the most common is through comparison of the percentages of national income, because this avoids problems of adjustment for both exchange rates and differential inflation rates. (It also introduces some problems of its own, but for comparisons between economies so closely interlocked as those of Canada and the United States, these are minor.) At present, the gap is nearly three percentage points of GNP, implying that Canada spends about three-quarters as much as the United States. This differential is almost entirely accounted for by differences in administrative costs, in the rate of escalation of physicians' fees, and in the intensity of servicing of patients in hospitals (Evans et al., 1989b; Evans, 1986).

PRUNING PRIVATE BUREAUCRACY

Canadians have, through their health care system, much less access to the services of accountants, administrators, insurance salesmen, specialists in public relations and marketing, and management consultants. The whole panoply of services provided by the private insurance industry, and charged for in the form of the net revenues of health care insurers, costs between five and six times as much in the United States as in Canada. The reason is simple. When the whole population is covered for everything, the costs of designing and selling policies, determining eligibility, and making rates all disappear. Much of the effort of a for-profit insurer must be devoted to determining who not to cover, and what not to cover, in order to hold down losses (consider AIDS). This is not inherent meanness; insurance companies make profits by collecting premiums, not by paying claims. The competitive marketplace forces them to try to increase the former while minimizing the latter; and they quite understandably devote a good deal of high-priced talent to both. But in a universal system, these functions vanish.

In addition, the costs of providers, both hospitals and other institutions, and professional offices and clinics, are significantly reduced because the staff required to deal with the payment system are minimal. The large financial apparatus of an American hospital has no Canadian counterpart, and the physician's office staff can be reduced as well (Himmelstein and Woolhandler, 1986). In the business services sector, the whole field of employee benefits is significantly simplified. The United States maintains a vast private bureaucracy whose function is to push around the bits of paper associated with health care (Reinhardt, 1988). Canada does not. The total impact of this bureaucracy on health care costs is difficult to estimate with precision, but the order of magnitude is conservatively about one percentage point of GNP, or about one-third of the Canada-United States differential—over $50 billion.

However, only part of this total bureaucratic cost (perhaps about half) shows up explicitly in the differential costs of the insurance system—prepayment and administration. The remainder is buried in the budgets of hospitals and, to a lesser extent, of physician practices and clinics, where it takes the form of costs of administrative and financial services necessary to establish patient eligibility for coverage, submit and justify claims, collect bills, and generally meet the demands of the payment system. These costs are recorded as costs of hospital and medical care, although they are really costs of the insurance system.

The gain in American health status from such activities is, however, easier to estimate: it is nil. The administrative overhead of the American system contributes nothing at all to health outcomes and contributes *negatively* to patient well-being. The compliance costs, of choosing and maintaining coverage (or trying to discover it!) and struggling over reimbursement entitlement, and the associated anxieties are again simply nonexistent in Canada. If there is a question about coverage, or appropriateness, which there rarely is, that is for the provider and the payer to sort out. The patient is not involved.

In military terms, the "teeth-to-tail ratio" is much higher in the Canadian system. A substantially higher proportion of resources is devoted to providing care and a lower proportion to pushing paper.

Nor is the effectiveness of the system reduced by leaner administration, because most of the "tail" in the American system does not in fact support the functions of the "teeth" component, the actual providers. Rather it is involved in an elaborate game of cost redistribution, of determining who will pay.

One could certainly imagine an administrative support system that *did* make a significant contribution to the effectiveness of care, for example, by monitoring and evaluating its impact and improving the knowledge base that lies behind clinical decisions. There is plenty of room for improvement in this area, everywhere in the world, and the Canadian record is not particularly impressive in this respect. But that is not, in fact, how most American administrative resources are now spent. This activity may be greatly expanded in future (Roper et al., 1988), and that will be all to the good, but it will also represent yet a further cost item.

A RESTAURANT ANALOGY: WHO CHOSE THIS PLACE ANYWAY?

The current American situation can be represented by the well-worn economists' analogy of a group of people going to a restaurant for lunch and agreeing to split the check equally. This is meant to represent the incentives in an insurance system, public or private, in which care is "free"—what you eat is mostly paid for by others. The usual argument is that all the diners will eat more than they really want—or more than they would eat if they had to pay the full cost—and the bill will be distressingly high as a result. Everyone will be unhappier than if they had all paid their own bills.[10]

But the story is incomplete. The maitre d' presents the bill, and indeed it is very high. In the American system, the diners immediately begin to argue about what their respective shares should be and to try to recontract out of their prior agreement to pay equal shares. As the dispute intensifies, they each bring in their accountants to justify their claims to a smaller share. Matters escalate, and soon the lawyers begin to arrive. All these backup experts are paid by the hour. The lunch becomes very expensive indeed, although the costs of arguing over the bill leave no one better fed, and do significant harm to the digestion.

The Canadian approach is different. There too, the bill for lunch is rather distressing, including items the diners are not sure were ever provided, others that seem to be overcharged, and still others that were not very good. But instead of arguing among themselves, to the relief of the maitre d' and the profit of their accountants and lawyers, the Canadians appoint a spokesman (the provincial government) and call in the maitre d' to negotiate the bill.

These negotiations may become acrimonious, and the maitre d' frequently insists that it is unprofessional for him to have to justify the bill. The consequences will be demoralization in the kitchen, deterioration of standards, and conceivably (though not yet) food poisoning. Sometimes he wishes he worked in the American restaurant next door, though he really would not want to put up with the shouting, pushing, and crowding, and he knows that staff over there occasionally get hurt in the melee.

The net result, however, is that the restaurant bill is lower than next door, and the total cost of lunch is much lower. But do the Canadians get less food or lower quality? Well, what else gets cut out of the bill? As noted above, the second and third components of the Canada-United States cost differential are physicians' fees and hospital servicing intensity.

CONTROLLING PHYSICIANS' FEES: PROCESSES AND CONSEQUENCES

In Canada, as noted above, physicians in each province are paid according to a uniform fee schedule, negotiated at periodic intervals between their provincial medical association and the provincial government. They cannot extra-bill the patient, and the schedule includes both procedural definitions and values and a set of rules of payment that define the circumstances under which particular fees are payable. These fee schedules have risen, averaged over time and across the country, more or less in line with overall inflation rates. Divergences in both directions are observed from time to time, depending upon the relative skill and bargaining power of the negotiators and particularly upon their success (or lack of it) in forecasting general inflation rates. Over time, however, these divergences tend to average out (Barer et al., 1988).

This is in sharp contrast to American experience where, with the exception of the early 1970s, physicians' fees have consistently outrun inflation. Thus a significant part of the difference in health care costs on the two sides of the border arises because, when physicians have to negotiate their fees with a single payer, those fees rise less rapidly. The "private market," at least in its present American form, supports a steady escalation in fees in real terms, adjusted for inflation. Bilateral negotiations do not.

Under these circumstances—"price controls" in an industry of self-employed practitioners—economic theory predicts unambiguously that the quantity of services offered by providers will go up, or down, or (less likely) remain the same.[11] Each of these possibilities has been forecast by participants in the American debate on physician fee schedules.

Cross-border comparisons suggest that in fact the increase in services, or at least billings, per practitioner *has* been slightly more rapid in Canada over the past two decades (Barer et al., 1988). The difference has not been large, however, and has not offset the difference in fee trends, so that overall costs have gone up more slowly in Canada. This is in part due to the rules for payment associated with the schedules, which have limited the opportunities for providers to expand their billings through procedural multiplication. In addition, some provincial governments have in recent years negotiated fee schedules in which fee increases are phased in over time and may be reduced if utilization rates rise too fast (Lomas et al., 1989). In a more open-ended system of payment such as in the United States, one might well find that attempts to limit fees were met by offsetting increases in servicing, unless corresponding measures were taken to limit their growth.

In any case, the Canadian and the American evidence suggests that controls on fees will tend to increase, not decrease, the volume of services offered by practitioners. To the extent that utilization of services is a proxy for access, fee controls at least do not impede access and are much more likely to enhance it. The real problem is not impeded access but "hyperaccess," that is, overuse. There are however two possible qualifications, only one of which can confidently be dismissed.

Most obviously, if fees were set in a hypothetical competitive market, with free entry and fully informed participants, the long-run effect of fee controls would be to discourage people from taking up medical careers. Supply would eventually dry up, in the way that rent controls are alleged to reduce the supply of rental housing. But of course medicine does not even remotely approximate the conditions in such a market. And what we find in reality is that in Canada medical school places are oversubscribed to an even greater degree than in the United States.

There are as many physicians per capita in Canada as in the United States, and this ratio is rising at between 1.5 percent and 2 percent per year (an increase several times the increase in "need" represented by the changing population age structure). By the end of

1989 the number of people per physician had fallen below 450, and the decline will continue for the foreseeable future.

The principal concern of those responsible for manpower policy is what to do to control the numbers. Some physicians do go to the United States, but not enough to affect the overall stock and, in any case, many come back. Thus fee controls have not impeded access to physicians' services by reducing their numbers any more than by reducing their work incentives.

A more subtle effect, however, might be to induce physicians preferentially to provide more remunerative services or to adopt a style of practice (e.g., short visits, frequent recalls) with higher payoff per hour. Servicing rates per capita would rise, but if the effectiveness of care were reduced (which it need not be), "access" might be interpreted as reduced. Indeed, access to needed services would be unambiguously reduced if physicians' time was completely taken up with the increased provision of less needed but more remunerative care.

This line of argument, which it must be emphasized is pure speculation, takes us back to the fact that the linkage between utilization and outcome is distinctly shaky in every health care system. Since we have so little information on the effectiveness of health care services, we would be hard put to know how to test this possibility. But there is equally no warrant for assuming that, if Canadian fees increased more rapidly, any resulting changes in patterns of practice—if they occurred—would result in improved outcomes. The assertion that physicians must be given whatever fees they ask for, or they will react in ways that will harm their patients' health, is an interesting commentary on the professional standards of practitioners, as well as yet another example of a circular argument, in a data-free environment, that any attempt at cost control must lead to harm. But it does provide further support, if such were needed, for gaining more hard information on the connection between servicing patterns and patient outcomes.

So the second thing that Canadian patients give up, in addition to the services of insurance salesmen, accountants, and management consultants, is some part of the lifestyles of their doctors. Canadian physicians are, like their American counterparts, at the top of the occupational income scale, but they do not earn quite as much, absolutely or relatively. The impact of this form of "reduced access" on the health of patients is rather difficult to detect, although it goes far to explain the concern of American physicians' organizations to protect their patients (and even those who cannot afford to be) from the disaster of universal public insurance.

HARDWARE AND HARD QUESTIONS: HOW WILL I KNOW WHEN I'M BETTER?

The third major area of expenditure differences is in the acute care hospital sector, and that is where the interesting questions of differential access and associated outcomes arise. It is also from here that the tales are carried south of the border about long waiting lists for elective surgery, insufficient and out-of-date equipment, and patients suffering or even dying for lack of care. Queues for medical services form, not because of a shortage of physicians, but because of insufficient provision of facilities, equipment, and personnel for physicians to work with (i.e., not because of too few cardiac surgeons, but because of too little surgical capacity). The situations described or alleged are multidimensional and complex and cannot be easily assessed with the sort of evidence that we brought to bear on the first two sources of cost differences.

To begin with, some of the stories are true. Waiting lists for elective surgery do build up at some times in some parts of Canada, and the availability of advanced diagnostic and therapeutic equipment, on a per capita basis, is less and sometimes substantially less than in the United States. There are periodic crises of access, and more often allegations of crises, and some people do go to the United States for care. But the explanation of these observations is much more complex than simply a global shortage of resources imposed by stingy or impecunious governments, and their implications for the health or well-being of patients is by no means unambiguous.

Like physicians, hospital beds are in ample supply in Canada and are heavily used. Canadians use one-third to one-half more patient days per capita in acute care than do Americans, about 1,200 days per thousand population per year, and occupancy rates average about 85 percent across the system as a whole. These compare with American average occupancies in the 65 percent range. Thus Canadians may appear to have less access to hospitals than Americans do, because with much higher average occupancy rates a randomly chosen Canadian hospital is much more likely to be full on any given day.

Yet per capita rates of hospital admission are remarkably similar in the two countries, just under 150 per thousand population per year, indicating that perceived shortages in Canada reflect higher propensities to hospitalize or more intensive use of facilities, rather than lower rates of admission. Canadians *do* get into hospitals and at about the same rate as Americans. And once admitted, Canadians stay longer on average; thus, they have substantially greater "access" to days of care.

There are several possible explanations for this greater utilization of patient days. The usual official story is that, because the public insurance programs were introduced for hospital care in the late 1950s and only 10 years later extended to medical care, Canadian physicians and patients both became used to an institutional style of care which has persisted to this day. But examination of American payment data shows that most hospital expenses (about 90 percent) are also covered by some form of insurance, while physicians' services are much more commonly paid out of pocket. Yet American patient-day utilization rates are much lower.

Another incentive arises from physician fee schedules, which do not cover the technical component of costs for many of the more expensive forms of diagnostic and therapeutic equipment—lithotripters, for example, or diagnostic imagers such as MRI, PET, or CT scanners. This limits physicians' ability to expand their incomes by setting up free-standing facilities and self-dealing by referring their patients. The expensive equipment is provided to the hospitals, where operating costs are funded through the annual global budgets. This both restricts the availability and use of such equipment and channels patients through the hospital.

But that does not explain the use of inpatient beds, since hospitals can and do provide a range of ambulatory diagnostic and therapeutic services. Just because the hospital owns, and is paid for, a particular facility or piece of equipment is no reason for physicians who refer patients to that facility to admit them as inpatients first. Certainly Canadian hospitals do not require this; after all they are not paid fees for service, and the hospitals with the high-technology equipment are not in general troubled by low occupancy. And in any case, if admission were required for access to high-tech equipment, that should be reflected in higher admission rates, not longer lengths of stay.

A third argument, frequently heard from physicians, is that acute care beds in Canada are being "blocked" by de facto long-stay patients who would more appropriately be cared for in some form of extended care facility. High levels of acute care utilization are alleged to reflect an inadequate supply of such facilities; this is, again, an "underfunding" problem.

Detailed analysis of the trends in hospital utilization, and of reported reasons for hospitalization, provides some support for this position but not very much. There has been an increase, over the last decade, in the numbers of acute care days identified as "patient awaiting placement," but this appears to be due in part at least to changes in the diagnostic coding systems. The ninth revision to the *International Classification of Diseases,* which was adopted in Canadian hospitals at the end of the 1970s, introduced this category for the first time, and physicians have learned over time to use it (Hertzman et al., in press).

Furthermore, very large increases *have* taken place in long-term bed capacity in Canada, without alleviating the alleged pressure. Canada has a rate of institutional utilization that is among the highest in the world. And, finally, even if reported acute care hospital use is reduced by arbitrarily removing all patients with lengths of stay of 60 days or longer, this still leaves per capita use rates well above comparable American rates (Evans et al., 1989a).

"IT'S JUST OUR (CLINICAL) POLICY"

One comes back to explanations of differences in practice styles of Canadian physicians and the lesser incentives for them to care for patients out of hospital. These are reinforced by the differential incentives bearing on hospital managements; global budgets are less strained when patients are kept longer, while item-of-service reimbursement rewards high turnover and plenty of servicing.

Canadian hospital utilization by acute care patients is in fact slowly decreasing. But the adjustment is taking place through administrative squeezes. While in the United States the prospective payment system provides financial incentives to reduce inpatient use, in Canada provincial governments achieve the same result by providing fewer beds than the medical staff would like or encouraging (pressuring) hospital administrations to convert acute beds to extended care and to set up alternative ambulatory facilities. The relentless increase in the supply of physicians, pushing against a relatively stable (per capita) bed supply, not only holds up occupancy rates but generates increasing pressure for individual physicians to economize on beds. Bed-to-population ratios are high and relatively stable; but bed-to-doctor ratios have been falling steadily for a long time, and this is forcing changes in practice patterns.

Physicians do not like the process. The administrative squeezes generate political conflict, claims of shortages, and waiting lists for care. But the problem is often not a shortage of facilities in absolute terms, but rather a conflict between government policies to encourage more use of ambulatory facilities, or simply less bed use, and physicians wishing to keep putting patients in beds because they have always done so. Hence one sees the paradoxical combination of "shortages" and waiting lists in an environment of apparent overutilization of inpatient care, at least relative to American practice. Over time, however, the necessary adjustments have been occurring, and inpatient utilization has been drifting down, although these trends have to some extent been masked by the simultaneous expansion of extended care wards within acute care hospitals.

This latter development makes it difficult to interpret the cross-border comparative data on hospital costs. Hospital expenditure per capita, adjusted for hospital input prices, has been rising substantially faster in the United States than in Canada for many years (Barer and Evans, 1986). This is consistent with the argument that, even if there is plenty of hospital space in Canada, much less in the way of diagnostic and therapeutic services is provided to hospitalized patients. The real problems are of access not to beds or doctors but to up-to-date technical services. The limitations on free-standing facilities in Canada point in the same direction.

But hospital accounting systems in Canada do not permit one to identify, on a systemwide basis, the share of acute care hospital expenditures going to acute care patients. And we know that the mix of hospital patients, and especially patient days, has changed toward a higher proportion of long-term care use. Consequently the intensity of servicing of the truly acute care patients may well be escalating substantially faster than is reflected in the aggregate data.

If one were to remove from both countries' data the proportion of hospital costs accounted for by financial and administrative activities, which is much larger and is growing faster in the United States, and then focus only on acute care patients, it is not clear that there would be a substantial difference between treatment patterns on the two sides of the border. The analysis has not been done, but there is some supportive expert opinion from clinicians and administrators with cross-border experience.

Moreover, recent cross-border comparative studies of the rates of performance of particular surgical procedures have shown that although the United States has higher rates for some complex procedures (e.g., coronary artery bypass surgery), the rates for other complex procedures (e.g., repair and replacement of heart valves and major peripheral vascular procedures) are as high or higher in Canada (Anderson et al., 1989). Procedural studies also show that in Canada, as in the United States, there are large and unexplained regional variations in the performance of complex procedures. Rates of performance of certain specific procedures—carotid endarterectomy, pacemaker implantation, cesarian section, and in some regions cardiac bypass grafts—are at levels that justify concern about overservicing and possible harm to patients.

That said, however, one still comes back to the fact that on a simple count of major high-technology equipment there is substantially more available in the United States than in Canada. Even though the Canadian facilities tend to be used more intensively, and partly in consequence have lower unit costs, it seems undeniable that Americans in and out of hospitals receive a number of such procedures and services (not all) at a higher rate than do Canadians.

Cardiac bypass grafts have been a leading example. Although the rates of increase are similar, many more procedures per capita are done in the United States. For bypasses in particular, complaints of insufficient capacity, long waiting lists, and patients going to the United States are common in the media.

This, finally, is where we come to the hard edge of the accessibility question. It is clear that improved access to the services of insurance salesmen and management consultants is not the primary objective of a health care system. Access to higher physicians' fees and incomes is also of lesser immediate priority, unless one happens to be a physician. But is not access to the services of MRI machines and lithotripters, or to cardiac bypass grafts, a more plausible primary objective? Well, in fact no, or at least not necessarily.

THE POLITICS OF SAVING LIVES—ON CAMERA AND OFF

The key point to remember is that nobody in his right mind wants health care services for their own sake. And the phrase "in his right mind" is used advisedly, because there is a mental illness, known as Munchausen's syndrome, whose victims want health care when they are not sick. The same point is made by the wisecrack that anybody who wants health care when he is not sick is sick. It is access to *needed* care that is critical, access to care that is effective, that has a demonstrable (positive) impact on patient outcomes.

But it is well known, and has been extensively demonstrated by students of health care utilization, that one cannot infer need from use. One cannot assume that, simply because Canadians use fewer of certain types of services, they necessarily suffer from a reduction in access in the sense of access to health outcomes. And that is what we are really interested in, not activity, however technically impressive, for its own sake.

Furthermore, there are adaptation processes in the Canadian funding system. It is by no means as stagnant and as starved for funds as it is sometimes portrayed in the American media. There Canada is frequently bracketed with the United Kingdom as virtually equivalent "horrible examples" of "socialized medicine," but the parallel is without merit except for propaganda purposes. As noted above, Canada has socialized insurance superimposed on a private delivery system and spends as much per capita as any other country in the world, outside the United States, on health care. Accordingly, when pressure points develop, more resources are available to remedy the situation.

The process of resource mobilization is, however, overtly political. The theater of shortages and unmet needs, what we have called elsewhere "orchestrated outrage" (Evans et al., 1989b), creates political pressures that define social priorities and determine where the resources are most needed—or where the advocates can mobilize the greatest political pressure.

Coronary artery bypass grafts are a case in point. Waiting lists and shortages are not the result of a refusal by provincial authorities to provide facilities; on the contrary, capacity and utilization are expanding rapidly. But cardiac surgeons are bringing people to surgery even more frequently, particularly very elderly people. This growth in "demand" by surgeons is outstripping the growth in facilities and utilization. Cardiac surgeons have in effect decided to reallocate public resources into this field (and to themselves) through a powerful political campaign, including elements of "disinformation."

But as in the United States, clinical practice in this area shows wide geographic variations that seem unrelated to patient needs (Anderson and Lomas, 1989). There are thus good grounds, reinforced by the equivocal or absent evidence from clinical epidemiology, for believing that some, perhaps much, of the surgery is inappropriate. Knowing this, provincial ministries of health have deliberately tried to restrain the growth of surgical capacity. But the political costs are high.

No one would pretend that such a process is perfect in its ability to match resources to actual needs. Indeed in the case of cardiac surgery the political process is looking quite vulnerable. But overall this approach does not look too bad when one considers the known alternatives.

And it would be quite misleading for outsiders to imagine, as many Americans do imagine, that the political theatrics indicate a system in collapse or even under markedly more strain than any other in the world. On the contrary, the ongoing political controversy is itself a form of solution to the inherently very difficult problem of setting social priorities with respect to health care and giving those priorities effect. Unlike the current situation in the United States, this solution, imperfect though it inevitably is, appears both acceptable and stable for the medium term at least. The American combination of rising costs and falling coverage, by contrast, suggests a system that is not dynamically viable; projection of the current trends indicates steadily increasing conflict and misery for a growing proportion of the American population.

THE MISSING LINKS: UTILIZATION, NEED, AND HEALTH OUTCOMES

It is in this context that one must consider the issue of relative accessibility of particular medical procedures and interventions on the two sides of the border. Substantial differences in utilization, for some at least, are readily demonstrable, but the significance of these for comparative health outcomes is unknown. A number of American researchers have concluded that certain procedures are greatly *overutilized* in the United States, far beyond what either scientific evidence or even expert opinion supports as beneficial or appropriate (Brook and Vaiana, 1989).

It is quite possible that Canadians are better off with less, in terms of straightforward health outcome. At least one knowledgeable American observer (Enthoven, 1989) has conjectured that more Californians die in the course of unnecessary or inappropriate heart surgery than Canadians die from delays. But it must be admitted that in North America and everywhere in the world, we know much less than we should about the positive and negative consequences of health interventions.

Until we do, it is not possible to say with confidence that no Canadian ever suffers as a result of inadequate access to health care, and indeed the statement is almost certainly not true. Would it be true in any other country? What is much more sustainable is the statement that the Canadian health care system suffers not from underfunding but from undermanagement (Rachlis and Kushner, 1989), so that the problems of access that do exist will not be remedied simply by throwing in more resources. Again the international evidence is supportive; health care systems in all developed countries display ongoing conflicts over costs and access, regardless of how much is spent on care. Would those Americans who feel that Canadians suffer from lack of access to certain services want to claim that their own much higher level of expenditure has solved, or even significantly mitigated, access problems in their country?

For that matter, it is a gross oversimplification to refer to levels of access "in Canada" or "in the United States" as if the national averages were representative of the entire of two very large and diverse countries. American researchers have clearly documented the wide diversity of patterns of care in the United States, diversities that show up between regions or states, and also among very small regions within states, but that cannot be shown to bear any relation to patient needs or outcomes.

Recent work by Wennberg and colleagues (1989) has even shown very large differences in average utilization and costs between Medicare populations in Boston and New Haven, each served by one of the most prestigious health science complexes in the world. Mortality patterns are the same in both areas, but it costs twice as much to die in Boston. Per capita use rates for particular procedures are even more variable. Which represents "American medicine at its best"? If per capita use patterns and costs in Boston were somehow brought into line with those in New Haven, a great deal of money would be saved for the American taxpayer. Would this represent the catastrophe of "rationing" in Boston but not in New Haven? Does "rationing" mean nothing more than holding providers accountable for what they do and spend?

But let us not pretend that the Canadian approach to funding represents an adequate response to this situation of apparently arbitrary patterns of use and cost. Inter- and intraprovincial variations are just as prominent north of the border. The most costly province in Canada—Ontario—may be quite similar to many states in the United States, while if one compared patterns of care and cost in Boston with those in, say, Quebec or British Columbia, spectacular differentials would emerge. Yet each is consistent with acceptable levels of care for a modern population.

Recognition of the extent of regional variation in each country underscores, heavily, the essential arbitrariness of patterns of medical care. This in turn demonstrates the patent absurdity of the claim (endlessly repeated by provider representatives) that any attempt at control must threaten the health of patients. This arbitrariness is the other side of the coin from the observation that a high proportion of the care actually provided in any modern health care system is of unevaluated or no beneficial effect in the circumstances in which it is given.

THE ROLE OF RESEARCH: GUIDE OR ALTERNATIVE TO ACTION?

The pervasive lack of knowledge about the effectiveness of health care provides strong support for a major expansion in research on the determinants of health outcomes. As a subspecies of that, research on the differences in patterns of care, and in outcomes, on the two sides of the Canada-United States border might be particularly interesting. American researchers appear to be well out in front of the rest of the world in such effectiveness research, although there are also several strong groups elsewhere.

But while a certain humility in the face of the vast unknown is both seemly and prudent for the scientist and the scholar, it can be remarkably dangerous for those responsible for public policy. The researcher will always assert that more research is needed; it is sometimes hard to distinguish modesty from marketing. One does not have to go over the Canadian experience with a fine-tooth comb, or turn it inside out, to decide whether it offers, in Enthoven's (1989) compact phrase, "politically feasible incremental changes . . . that have a reasonably good chance of making things better."

Those who argue that, until the differences between Canada and the United States are mapped and understood in much more detail, no secure conclusions are possible are both marketing their own services and providing a very powerful defense for the status quo. That might be a more plausible position if there were fewer problems with the American status quo.

Thus while there is clearly much more that can be learned from comparative research on health care patterns between the two countries, it is quite wrong and dangerously misleading to suggest that such detailed research is either necessary or sufficient for the design of American policy based on Canadian, or other international, experience. The fundamental issues in health care policy are political, not technical, and an attempt to portray them as amenable to "scientific" solutions is simply part of that political process, often with researchers as conscious or unconscious participants.

Moreover, even in the technical sphere, "life is the art of drawing sufficient conclusions from insufficient premises." Hegel's comment that Minerva's owl flies only in the darkening twilight can be interpreted to mean that by the time the facts are all in and the situation fully understood, the game is long over and players and spectators have all gone home. "More research is needed" can easily be a stratagem for delaying action until the window of political opportunity has closed.

I think we now understand how and why the Canadian health care system works, after watching it for 20 years, much better than did the people who designed and established it. They were by no means totally ignorant; they had spent a lot of time drawing inferences from the examination of other experience and thinking pretty hard. But they certainly did not have the quality of data that would be published in the *New England Journal of Medicine*. What they did have was quite a lot of courage and the will to begin.

DO RIGHT, AND YOU MAY BE RIGHT, BUT BE PREPARED FOR THE LONG HAUL

Perhaps even more importantly the architects of the Canadian system had a moral vision of what a good health care system, in a decent and humane community, should look like. That moral vision carried them through a great deal of technical uncertainty to the national legislation, unanimously adopted, which one of the leading Canadian commentators has called "a leap in the dark." And it has paid off, with a system that is (relatively) affordable and accessible, apparently sustainable, and remarkably popular.

Universal coverage, in a single-class, single-payer system, with the financial burdens spread according to ability to pay, through the tax system, rather than according to needs for care, has turned out to be not only morally but economically sound, even if the latter was not central to the original intention. Americans may not wish to adopt, and may not be able in their context to adopt, an exactly similar system. But as far as we can tell, any successful funding system will have to have those same characteristics.

Furthermore, any funding system must have built into it a combination of adaptive intelligence with a fairly stable framework. There is no once-and-for-all set of rules that can be established, after which the funding of health care can become as automatic a process as eighteenth century clockwork. Instead, health funding is an ongoing game among parties with interests that are inevitably opposed but who are committed to the game. Their strategies will evolve, as they react to each other and as the external world changes. But they must also have enough continuity in structure and personnel to learn how to play the game without tipping over the board. The conflict between payers and providers must be channeled and contained, managed as constructively as possible. It will never go away. The High Noon scenario in which the bad guys (government bureaucrats? the AMA?) are confronted and dispatched is a story for children; the dream of an objective scientific solution to an inherently political problem is equally mythical.

And, finally, this funding game is everywhere a collective process, managed through organizations that pool financial and political interests. In Canada, as everywhere else in the developed world, this process is managed to a greater or lesser degree by the state. Only in the United States, for historical and ideological reasons, is there so firm a commitment to finding private structures within which to manage the funding of health care.

One cannot say that this is impossible; there are in the United States a number of very good and innovative minds working hard on the problem. The fertility of their ideas explains why European countries, Canada included, maintain such an interest in organizational developments in the United States, even though the operating characteristics of the American system are grossly inferior to their own. But one can, I think, say confidently that no other country has tried to run its health care funding system through the private sector and that the American record to date is not one of success. If the United States ever pulls the trick off, the international interest in American models will rise severalfold. But at the moment the dominant American approach looks like a very long shot indeed, being pursued only because the ideological constraints are so severe that the obvious is not permissible.

Meanwhile, as the pressures build, recall that not too far away, in a country more similar to the United States than any other in the world, a pretty decent system is functioning to general satisfaction. If the art of the possible should become more attractive than ideological purity or technical virtuosity, some of our experience may be helpful. For the moment, despite the widely trumpeted inadequacies of the current American arrangements, I suspect that not enough (politically relevant) people are really suffering. But that is probably only a matter of time.

NOTES

1. The somewhat less grandiose claim that "*At its best*, American medicine . . . etc.," while less self-evidently false, contains a rhetorical boomerang. This statement could perfectly well describe a system in which a small privileged class received the world's best and the care of the rest of the population was mediocre or worse. It is thus remarkable that anyone would regard this claim as grounds for pride, without further elaboration as to what proportion of American medicine meets such a standard, how far short the rest falls, and how access to "the best" is determined.

2. As Taylor points out, most Americans do seem to be happy with *their own* health care; it is the system as a whole that they report as unsatisfactory. Since a substantial majority of Americans have good insurance coverage and ready access to services, this is no paradox. Care is both accessible and affordable for most individual Americans; it is the global cost and the large minority who have inadequate or no access that lead to systemic concerns.

3. "Affordability" drops out of consideration as an independent criterion at this level of generality because the program consists of its benefits *and* its costs. If the program really "works," and if the population is happy with the balance of benefits and costs, then clearly it is affordable. The population served has chosen to afford it.

4. This statement presupposes that a prior decision has been made to deal with the allocation question politically, rather than through the marketplace in which people have different numbers of votes according to their wealth. The justification for this approach is both that in the real world no society, not even the United States, has been willing to let the marketplace govern health care matters and that, if any society did so, the aggregate issues of affordability and accessibility would be meaningless. Who, other than individual buyers, worries about the accessibility and affordability of Mercedes-Benzes?

5. This is not the only reason; considerations of social solidarity and the symbolism of caring may justify promoting access to care of dubious or no therapeutic value. But anticipated health benefits are the central issue.

6. The significance of that qualifying phrase has never been explored. It excludes elective cosmetic surgery, though obviously repair of traumatic damage or congenital defects is covered. Conceivably the legislative phrase could serve as a basis for "deinsuring" services evaluated by expert opinion as having no actual or anticipated benefit, but this has not been tried.

7. As Reinhardt (1989) points out, there is another option: writing down the shareholders' equity to reflect the capitalized value of the previous commitments. This is also unpopular and in any case is only a one-time response. Even if there were no commitments to retired workers, firms with older work forces would still be faced with a choice between higher costs, lower money wages, or lower benefit coverage relative to their competitors. The "perfectly competitive" marketplace would, one way or another, impose lower take-home wages on older workers.

8. However gratifying to American national pride, this interpretation has had considerable difficulty with the international spread of successful cost control in the 1980s, especially the pronounced *fall* in the share of spending to national income in Sweden and Denmark and its stability in Japan. The argument never did look very strong in Canada, where, except for the 1982 recession, the health care share has been more or less stable since 1971.

9. In the United States the professional rhetoric may make a politically expedient reference to the forces of the competitive marketplace at this point, but the formal and informal institutional arrangements of the medical profession have heretofore been sufficiently powerful to ensure that the market works weakly, if at all, even when supply is increasing rapidly.

10. Even on its own terms the analogy is inconsistent. If the diners are completely selfish, as the example assumes, and take no account of the impact of their behavior on others, then why did they agree to go to the restaurant together in the first place and split the check?

11. One cannot base predictions on a positively sloped supply curve, because the opportunity cost of the professional's own labor is the predominant component of "firm" costs, and this cost is positively correlated, through income levels, with output prices. Furthermore, a large share of the return to labor is in fact a quasi-rent to the human capital embodied in the profession; entry to the field is not free and input mixes are constrained by regulation. Under these constraints, a backward-bending supply curve both of own time and of total output is not only possible but quite likely.

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Response to Robert G. Evans

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William L. Roper

During most of my tenure,* I have had a standard speech that I give about health policy. The speech always begins with the line that we in the United States have the finest health care system in the world. I'm not going to do that this time, because I don't think that's a useful place to begin the debate. I'd rather begin by saying that we have some problems in our health care system here in the United States: the cost of our health care system, the tens of millions of American without adequate health insurance, an all too high infant mortality rate, AIDS, long-term care, to name just a few. The challenge for us is how to set about solving those problems. Comparisons with other countries are helpful and instructive. In response to the views presented by Dr. Evans, we must ask, "What lessons do we draw from the Canadian experience about what we should be doing here in the United States?" I'm one of the many who have made pilgrimages to Canada. I believe they have organized offices in Ottawa and in the provincial capitals to talk to Americans because there's a growing stream of people headed north these days. I believe we can learn from the Canadian experience that it is possible to cover the whole population and provide an acceptable level of health care for a substantially lower share of gross national product than we are

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*At the time of this speech, Dr. Roper was deputy assistant to the president for domestic policy and director of the White House Office of Policy Development. He is currently director of the Centers for Disease Control.

now spending in the United States. Further, I think we can learn from the Canadian experience that a national consensus leading to a coherent national policy can be very helpful. A more outspoken friend of mine suggested that I should simply say that we have an out-of-sync health care system because we have a convoluted political system.

But let me ask, policy aside, would the adoption of the Canadian model be politically feasible in the United States? We've got a great tradition in this country of incremental change. That's one of the dominant themes, persistent themes, in our democracy. The Canadian model would represent radical change for us. It would put out of business hundreds of companies—health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other financing organizations. It would require raising taxes and adding hundreds of billions of dollars to public expenditures. Such a strategy would almost surely attract the determined opposition of my colleagues in medicine. I'm persuaded that the hospital industry and other provider groups would likewise be opposed to accepting a single monopsony purchaser.

All that notwithstanding, I think it is worth moving on to ask whether a Canadian system would work as well in the United States as it does in Canada. In Canada, at both the national and the provincial levels, there is a parliamentary system of government with strong party discipline, much less vulnerable to special-interest pressures than is our system. Our founding fathers gave us a system in which it is very cumbersome, very difficult to make decisions and that has consequences. To try to craft a single national payment system in the United States is a much different proposition than it is in a nation with a parliamentary system of government.

A final point that I'd make is that the Canadian model appears locked into fee-for-service medicine, in my view, an increasingly unsatisfactory mode of payment. Our experience and that of Canada, Great Britain, and other nations shows us that when the government takes over an industry, that industry is frozen in place and becomes extremely difficult to change, innovate, or close down. Witness the experience of an unneeded military base or an unneeded post office. I contend that the Canadian model directly applied here would freeze our health system and block a great deal of badly needed innovation. I believe we need innovation in the development of managed care systems. Also, we need to raise the real question about technological progress in Canada and the United States. There's an open border that presents a "free-rider" problem that makes comparison difficult. It has been said that Canada has controlled costs without adverse effects, but there are some adverse effects. I don't mean to maximize these, but there are growing reports of waiting lists, lack of leadership in the development of new technology, and so forth. I believe that much more work needs to be done to compare what we in this country are getting for the additional share of our resources that we are devoting to health care. There are real differences in culture and values between the United States and Canada. But we need to seriously question whether we here in the United States are really getting additional value of sufficient merit to allow us to continue to spend so much more for health care.

Let me pause for a minute to raise a question about the often touted degree of satisfaction in Canada with their system (which I do not doubt) and the comparison that's drawn to the dissatisfaction in this country about our health care system. Recently there were reports of a Lou Harris poll that asked people in this country, in Canada, and in Great Britain to rate their preferences for their own health care systems and those of their counterparts in these countries. One question asks: "In the Canadian system of national health insurance, the government pays most of the cost of health care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals. Under the Canadian system people can choose their own doctors and hospitals. On balance would you prefer the Canadian system or the system which we have here?" Not surprisingly, according to Lou Harris, in the United States 61 percent of the respondents said they preferred the Canadian system as contrasted with 37 percent who said they prefer it here. That's not surprising, because remember the question said, ". . . government pays most of the cost for everyone . . ." and then went further to say, "government sets the fees for all doctors and hospitals." It is increasingly popular, not only for Health Care Financing Administration (HCFA) officials but for the general public to bash doctors. And to ask people "do you like a system that controls people in medicine?" I think is asking for them to say yes.

To return to the United States, I think we must deal seriously with the problems of the uninsured and infant mortality and the other serious deficiencies. I believe we are at least beginning to deal with those problems. After all, we're in a kinder and gentler America. However, we're not beginning to do so quickly enough. I think we need to move on with the business of protecting those most vulnerable among us. The central question before us and before Canada as well is whether we are truly getting value for our health care dollars, either U.S. dollars or Canadian dollars. That's why I, Secretary Sullivan of Health and Human Services, and others are stressing the importance of an effectiveness initiative, stressing research into medical practice, developing information on what works in medical practice.

The Canadians, the British, the Germans, and others are interested in our progress. It will be gradual progress but I think important progress nonetheless. And I am particularly pleased that Congressman Gradison and Senator Mitchell have introduced legislation in this area, providing additional momentum toward this effectiveness initiative.

In face of the changing issue of effective medical practice, it's hardly any wonder that people are focusing attention on the growing volume of services, particularly physician services. It's this volume of services that's the dominant explanation for the expenditure growth, the exploding expenditures that we are seeing, particularly in the Medicare program. There was 16 percent growth last year just in Medicare Part B. Even under the changes that are currently being negotiated with Congress, we are still projecting very rapid growth in costs. And that's why, I believe, we need to focus attention again and again on this question of volume of services and what value we are getting for those services.

In Canada, they are also concerned about volume growth. Several of the provinces are discussing a plan to begin utilization review of physician decisions. Until now, the lack of individual physician review has been a major difference between our system and that of Canada. This externally imposed review of individual decisions made by doctors is probably the most contentious part of the American health care financing system. It would be far preferable if we could find a system, and I think we can, in which doctors manage themselves and their colleagues instead of having the government or other payers impose a system from without. In Quebec, where they have individual physician expenditure growth limits, the government has been the most successful in constraining spending. They have dealt with overall expenditures at the individual physician level, not just controlling prices for all doctors, but prices and quantity for individual doctors.

Price controls alone are certainly not sufficient to control expenditures. We must ask, "Is it really worth investing the lion's share of our analytical and technical and political resources in substituting the fee-for-service payment system that we now have for another, without dealing with the overall question of the volume of services, the intensity of services?" That is why serious people here in the United States and in Canada (in provinces other than Quebec where they already have it) are discussing expenditure targets as a means of limiting aggregate spending for physician services.

What does all this mean for us? Part of this debate about our system and Canada's system contains an unspoken assertion that we here have tried everything possible and have failed miserably in our attempts to constrain health care costs. I believe that we have not seriously tried a more competitive system in America. An absolute minimum requirement for a more competitive system is for consumers to see and to share more of the cost of the system at the margin. We persist with a tax policy and with payment policies that shelter consumers from the true costs. We just haven't been disciplined in trying a more competitive system. I believe we can do better, and we ought to commit to that effort. I further believe that in the United States we must follow a health care policy that respects American cultural preferences for self-reliance, local decision making, private action, pluralism, multiple competing systems, and individual choices. And in the United States that means using market forces and competing managed care plans to sort out more cost-effective ways of providing quality services. Given our conservative political system, change is going to be incremental, and that's to be applauded. But we need to move ahead to solve especially the pressing access problems that we face. I believe access will be improved through improved public programs (especially the Medicaid program) and through incentives for private plans to improve their coverage of people not covered by public programs. To improve value we need to pursue the study of effectiveness and the information on clinical practice that is made available to doctors. These kinds of strategies can offer a real side benefit for physicians by their potential for providing relief on malpractice lawsuits through the distribution and use of practice standards or guidelines.

For the long term, it seems an open-ended fee-for-service system is simply not sustainable. That's why I favor increasing reliance on prepaid managed care plans. The alternative, at least in the short run, is greater use of utilization review, which harasses doctors, which in turn is likely to produce much more unhappiness and not the result that we all would seek. If not, we will need to turn to expenditure targets or caps on total spending. Unfortunately, resorting to external controls represents a real threat to professional morale. And again, that is why I stress that we must increase reliance on internal controls in managed care plans, in which doctors monitor themselves, pick their own business partners, and develop their own rules.

There are limits to the federal budget, as we witness daily by reading the newspaper. And there are competing interests within that federal budget—child care, education, and the like. We have a number of problems within our health care system in the United States. I've recited a list and one can imagine others. I profoundly believe, though, that one of those problems is most assuredly not too little money. We have plenty of money in our health care system; the challenge we face is how to spend it better.

Health Policy at the Local Level

Henry G. Cisneros

Before discussing health care policy at the local level—where all strategies touch people's lives—it is useful to look at the public policy environment likely to prevail during the 1990s and beyond.

Two profoundly important demographic trends are shaping the appearance and the character of our nation. One of them is the aging of the American population. The other is the growth of ethnic minorities in the younger age groups.

The aging of America has been well documented, but the magnitude of the related changes has not fully reached public awareness or adequately influenced public policy. Every week in America 210 people, on average, reach 100 years of age. The fastest growing age group in our country is made of people entering their eightieth year. The 1990 census will tell us that, for the first time in American history, our society will have more people over 65 than teenagers. At the turn of this century, the average American male spent about 3 percent of his adult life in retirement. During the century that lies ahead of us, the average American male may spend as much as 30 percent of his adult life in retirement. This is not just an American phenomenon. It has even larger dimensions in Japan and in Europe. And in West Germany, where one finds the largest proportion of older citizens among industrialized nations, it is possible to observe right now the consequences of a graying society on health and other social programs.

The fact that people in their older years will represent a larger part of society has, per se, no policy significance. The United States always has been able to handle large numbers. But in this case the phenomenon is combined with economic and social dynamics that reduce the rate of growth of the younger population groups. For instance, women are working in larger numbers than ever before; consequently, they are postponing childbearing and giving birth to fewer children. The result is not only larger numbers of older persons but a larger percentage of them relative to the total population.

The challenging question we must address is how future-oriented American society will be. A nation traditionally viewing its best days as yet ahead, a nation with a history of adopting successfully an investment philosophy, may well find itself facing the political reality of large groups of citizens who, having already paid for education, may choose not to vote for bond issues or for increases in property taxes needed to improve school programs. Last year in the Florida Democratic primaries, 47 percent of the voters were persons over 60 years of age—almost half of the total vote. Those older citizens had 75 percent voter turnout rates, while citizens in their twenties had 20 percent rates.

This reality must be seen in the light of the other demographic trend mentioned above: the growth of ethnic and racial minorities with a demographic profile decidedly younger than that of the country as a whole. While the median age of the American population is 32, that of Hispanics is 23, that of blacks is 25, and that of other minorities collectively is 26.

It is not an accident that the recently elected mayor of New York is African American. Nor that the mayors of Philadelphia, Baltimore, Atlanta, Birmingham, and Los Angeles are black. It is not an accident that a Cuban American is the mayor of Miami or a Mexican American the mayor of Denver. Nor is it an accident that women have assembled progressive coalitions including minority groups and have become mayors of Houston, Dallas, San Antonio, and San Diego. All these events are reflective of fundamentally new demographic realities in the nation's cities.

These realities are now transforming some of our most populous states. For example, California, the state with the largest population, is home to 27 million people; the next largest, New York, has a population of 17 million. It is easy to see why California is so important to this country. Besides its "people power," if it were ranked according to economic indicators as an independent nation, it would be the sixth most powerful country in the world. Last year the RAND Corporation did a study for the California State Library System to estimate the future utilization of this major governmental service. It concluded that in the year 2000, a short 10 years from now, California will be 46 percent Hispanic, Asian, and black. San Francisco County will be 65 percent Hispanic, Asian, and black. Los Angeles County, not the city but the county, 10 million people strong, will be 60 percent Hispanic, Asian, and black. Orange County, a traditionally conservative population center, will be 40 percent Hispanic, Asian, and black. Among the rural areas, the Imperial Valley will be 73 percent Hispanic, Asian, and black. In the year 2000, fully 92 percent of the people of California will live in a county where at least 30 percent of the population will be made up of Hispanics, Asians, and blacks. Thirty percent certainly constitutes a cultural presence. Immigration will have an important impact on these trends. Indeed, projections indicate that a large portion of the overall population growth will be the result of growth among nonnative citizens and undocumented persons, a fact that simply accentuates the diversity of needs to be addressed.

These statistics leave many people perplexed. Some even suggest that actions should be taken to stop the changes. But the numbers cannot be easily regulated. In fact, injections of younger persons into an aging labor force may be considered, given adequate training, a source of competitive advantages and, therefore, a favorable phenomenon. However, if the figures are not something to worry about, they are something to prepare for. They represent the mathematically predictable demographic future of our nation. And they have major implications for public health care policy.

For example, Hispanics, projected to become the largest population group in several of our key states, will experience three to five times the incidence of diabetes compared to non-Hispanic whites. This fact in itself calls for a health policy response of a different scale than what we have relied on in the past.

The incidence of cancer of the cervix among Puerto Rican women in New York is three times that of the general population of women. The expected dramatic growth of that population amplifies an already significant health issue.

Among pregnant black women only 60.6 percent receive early prenatal care compared to 81.6 percent of white women. When the higher fertility rate of ethnic minorities is taken into account, one can easily predict that the provision of early prenatal care will emerge in the near future as a key health issue.

Hispanic children ages 5–11 years old are twice as likely as non-Hispanic white children never to visit a dentist. Again, we can easily predict that oral health and dental policies will need to be different in the future.

The Task Force on Black and Minority Health of the secretary of

Health and Human Services has identified specific health problems that place minorities disproportionally at risk relative to the rest of the population. Each one of these problems will become a major challenge for policymakers as minorities increase in number and relative importance in our multicultural society. The challenge is clear. It becomes even greater as we look at the financing of health care and health surveillance and discover how many people in the minority communities have no health insurance. Fully 33 percent of Hispanics and 20 percent of blacks are covered neither by private health insurance or by a governmental program such as Medicare or Medicaid. These statistics compare with only 11 percent of persons who are not covered by insurance in the nation as a whole. Again, we are facing a predictable hardening of certain financing and surveillance issues.

We have just looked at a dimension of our future produced by the convergence of two massive demographic trends. Another dimension is created by economic forces. I won't dwell on the changes in the American economy because they have been discussed at length elsewhere. I will highlight, however, their implications for the distribution of income and, therefore, the distribution of access to health care and health services. We are witnessing the transition of a natural-resource-based economy needing large numbers of blue-collar workers into an economic system depending on information technologies, automated systems, and fewer production workers. The economy that once required strong arms and strong backs today needs higher levels of education. The supremacy gained by this country amidst limited international competition is now chipped away by strong global challengers that have taken advantage of the information explosion, the opening of new markets, and the shrinking diffusion time of knowledge and technology.

Decisions made about the introduction of a new technology in Japan may result in job losses in the United States. Decisions made about the price of oil and gas in the Middle East decimate, almost instantaneously, the economies of Texas, New Mexico, Louisiana, and Oklahoma. Decisions made about a bad harvest in Argentina affect grain prices, commodities, and jobs in the Plains states. Wealth and jobs originally anchored to mass production in large domestic industries are created today by small businesses in dynamic entrepreneurial settings.

This global reality worsens the effect of the structural demographic changes discussed earlier. The dislocation of our urban minorities from the vanishing blue-collar jobs to the low-wage service jobs, such as those in fast-food restaurants with few opportunities and no fringe benefits, is well documented. These trends produce widening differences in the distributions of income and a most un-American phenomenon, that of a permanent underclass.

In 1987, the top 20 percent of Americans ranked by income received fully 43 percent of the nation's total income—the largest percentage received by the top 20 percent of the population since the end of World War II. The bottom 20 percent received only 4.7 percent of our national income, the smallest percentage in 25 years. In the mid-1970s, the ratio between the top 20 percent and the bottom 20 percent of the population, relative to earnings, was 7 to 1. Last year the ratio was 9 to 1, and it is growing larger.

We are witnessing the hardening of an underclass. From 1974 to 1987, the number of households with incomes below $5,000 per year increased from 4.7 million to 7.2 million. As one might expect, the number of persons unable to be covered by health insurance has been increasing. Concurrently, traditional health insurance has had dramatic increases in premiums, has been screening out the poorest risks, and is progressively abandoning the coverage of individuals and small employee groups. The relationship between the structural changes in our economy, the widening gaps in the distribution of income, and the hardening of an underclass with decreasing access to medical services is clear.

A third dimension of the future is related to the actions of governments. The federal government has chosen to withdraw from many areas of domestic responsibility. When I became mayor of San Antonio in 1981, the federal budget for cities included some $69 billion in emergency programs. In 1989, the federal budget included approximately $17 billion for such programs. In 1979, $31 billion were earmarked for urban housing initiatives. In 1989, that number was $6.9 billion despite the fact that over that time the number of homeless persons had increased.

In the health arena, the federal government relies on Medicaid as the bedrock of health services for poor America. Yet only 45 percent of the poor are covered because of the program's link to welfare and Aid to Families with Dependent Children (AFDC) income thresholds and cost-shifting strategies at the state level. Due to the continuous retrenchments in our domestic agenda, one-half of poor children under 18 are left uninsured.

This erosion of insurance coverage is a serious problem indeed. Some have suggested mandating coverage from the federal level, but I do not believe that this is a feasible remedy. Others propose better insurance coverage for more employees through business tax incentives, but tax incentives are also tax expenditures, and it is unlikely that this type of additional federal expenditure will find sufficient support in a political climate predisposed to reject any financial outlay not balanced by a counteracting revenue. With the dominant mood in the nation's capital driven by the federal deficit, we may not see over the next several years major federal initiatives directed at increasing health services.

The mixture of demographic changes, economic trends, and current political climate will shape the health care environment for the 1990s and beyond. Sadly, one-third of the children born over the next decade will live, at best temporarily, below the poverty level. And, due to the worsening of non-disease-specific factors such as real earnings and illiteracy, we are likely to see drug abuse and AIDS become increasingly critical. I regret the gloomy nature of the picture I have drawn, but it is a worrisome reality. Our task now is to suggest local models of response to the health care needs of our communities. Ultimately, it is at the local level that public health policies can be made effective. The strategic importance of this fact has increased, since, for the time being, federal initiatives are not likely to play a major role in improving health care.

Let us begin by taking just a slice of the problem, such as maternal, infant, and children's care. Children born underweight and malnourished are likely to have a problematic life. When malnutrition continues during early childhood, brain growth is severely compromised. If the condition continues over a two-year period, the chances for remediation diminish drastically and permanent brain injury occurs. The magnitude of the problem is highlighted by the fact that maternal and newborn services make up 25 percent of hospitals' uncompensated care and that 35 percent of the uninsured hospital discharges are maternal and newborn. This means that a large portion of the new additions to our population, the children who will inherit and shape our future, are having difficulty in gaining access to basic health care services.

Among the emerging urban pathologies are malnutrition in children, chemical dependency in mothers and youths, and child abuse. These problems are followed by anxieties of shortened childhood due to early encounters with the traumas of urban survival, by stress reactions to these traumatic experiences such as depression (usually left undetected in younger persons because of inadequate health monitoring), neuropsychiatric problems without access to remedial education, sexually transmitted diseases among adolescents, teenage pregnancies, and AIDS.

Recognizing the urgency of the problems, the U.S. Public Health

Service, in the recently released "Year 2000" objectives for the nation, set forth some important goals. Under the title "Reduced Infant Mortality," the goal is to reduce deaths among children under one year of age from the current 10.4 deaths per 1,000 births to no more than 7. For the black population, the target is to bring the number down from 18 deaths per 1,000 births, which is the current baseline, to 11 per 1,000 births. Observing these numbers carefully, one realizes that the goal for the black community of 11 per 1,000 births is higher in the year 2000 than the baseline of 10.4 per 1,000 births for the general population today.

Another goal, that of reducing low birth weight (that is, newborns weighing less than 2,500 grams at birth), would attempt to ensure that only 5 percent of all births are characterized by low weight as opposed to the baseline in 1986 of 6.8 percent. Again, for the black community, the target is 9 percent, down from an unacceptably high present level of 12.5 percent.

Under the title "Increasing the Proportion of All Pregnant Women Receiving Prenatal Care in the First Trimester," the goal is to provide prenatal care to 90 percent of American women at the early stage of pregnancy from a baseline of 75 percent in the general population. The corresponding baseline statistic for black women is 61 percent; for Hispanic women, 60.3 percent; and for Native American women, 60.7 percent.

How does one translate goals into services that reduce infant mortality and low-weight births, or increase the number of women receiving prenatal care in the first trimester? I have already asserted that many of the strategies need to be local. But what are the major elements of the approach?

The approach must involve a comprehensive system of clinics reaching the higher-need areas of central cities. This requires cooperation between cities and counties and the negotiation of strategies for delivering and financing services on a scale that we have not seen before now, that is, sharing the burden of programs so that countywide hospitals will accept the responsibility of central-city obligations. Clinics must be complemented by multiservice centers characterized by holistic approaches to family needs. These include counseling services, educational assistance, job assistance, and other non-disease-specific assistance addressing both health and socioeconomic needs. These services must be physically accessible—near public housing projects for example—or include a transportation network. Other important components of these multiservice centers are parenting programs in which young mothers are taught the basics of nutrition, hygiene, and child care and mental health programs offering counseling, crisis management, and problem-solving skills in a manner that addresses the unique needs of a multicultural and often bilingual population.

The centers must be linked to other public systems, such as the schools, in order to provide health monitoring of children in schools and after-hours utilization of the facilities for health education and other social services that involve the whole community.

Beyond accessible multiservice centers we must reach out to those who live at the margin of urban communities. This means reaching addicts and the homeless where they are, frequently in the streets or in specialized centers. It also involves making special efforts to reach those who are most vulnerable to the risks of alcohol, drugs, and poor nutrition. The challenges are staggering. But there are underutilized areas of strength. We have been failing to take full advantage of civic action in the design of local strategies. Churches, for example, can use their persuasive power to motivate the poor and the handicapped. Grass roots community organizations can literally go house to house and bring people together at meetings. Senior citizens groups, continuously growing in size and availability of skills, can play important roles in counseling and technical assistance. On a personal note, I see my own parents involved in this way. My father suffered a stroke in 1976 and, after a life as a civil servant and a colonel in the Army Reserves, was unable to continue working in his profession. Today, he sits with first- and second-grade special education children at the local Hispanic neighborhood elementary school, providing them with a male role model and himself with a productive and fulfilling way of using his talents. My mother serves as a board member and volunteer at an organization named ADVANCE, a center dedicated to teaching parenting skills to low-income mothers. She dedicated her life to being the best mother in the world and is ready to share her experience and insights with other young women. They are an example of what people in their sixties and seventies are available to do. They are a resource that we have not sufficiently tapped.

Any model of access requires funding, and to meet that challenge several levels of partnership must be put in place. Funding must be increased at the local level even if doing so is a most difficult task because local governments have limited resources. I feel strongly that we must appeal to metropolitan-area-wide strategies. It is neither possible nor equitable to place the entire burden for effective health services on central-city governments while the benefits of the services are shared with a surrounding region.

In Hartford, for example, 92 percent of the children in the city's school system are black and Hispanic. But Hartford is a city of only 195,000 people. Therefore, the school system is very small, and its resources are a fraction of what they could be if the system were supported by the larger metropolitan area, which has a population approaching 800,000. Hartford, as the capital of Connecticut, is the economic and governmental center of the richest state, in per capita income, in America.

It is critical to fuse metropolitan and regional strategies. One approach might be that of creating incentives by the federal government for areawide funding mechanisms—for example, a block-grant-type program, similar to the Community Development Block Grant Program used for housing and physical development, in which areawide strategies would be a prerequisite to higher levels of federal funding. The approach would target matching funds to communities that have negotiated areawide strategies for health services cooperation between counties and cities or between outlying suburbs and central cities.

At this point, one might raise the question of the federal government's role. I will not claim originality for my ideas on what the federal government ought to do, but I take my cue from the National Leadership Commission on Health Care, a distinguished group of Americans who recently published recommendations for public and private action relative to three critical issues: access, cost, and quality. The recommendation on the question of access is that the country should commit itself to a national basic package of health services, some to be financed by employers in the form of standard health benefits, some to be financed by employees who desire and can purchase additional coverage, and some by individuals who can buy personal insurance. For the 31 million Americans presently without any coverage, the group suggested universal access financed with premium payments from those with incomes of 150 percent or more over the poverty line. To reduce the number of persons depending on the universal access budget, the commission recommended that employers be induced to extend coverage to more employees through special incentives. To avoid creating additional bureaucratic layers, the commission recommended that the program be administered by existing state agencies and that the authority of increasing benefits to address special needs, establishing payment policies, and negotiating with local providers be left with the states. The emphasis is on cooperation across sectors, payers, providers, and users.

Combining the proposal of the commission with what I suggested earlier for delivering health services at the local level produces a national access strategy that leaves guidance and some funding support at the national level, assigns fiscal responsibilities mostly at the state level, and creates effective delivery mechanisms as a result of local initiatives. The key elements of this approach are:

1. Universal access to a basic package of health care with optional state enhancements above that level.
2. The retention of individual choices and responsibilities for maintaining acceptable levels of care.
3. The expansion of the existing insurance systems through incentives and disincentives to employers.
4. In addition to apportioning the universal access costs among those who can pay, new revenues are required to raise the health status of those left out by the present system.
5. The reduction of inappropriate care and a focus on quality and effectiveness.
6. An enhanced role for the states in operating and monitoring programs for the uninsured and in negotiating fair compensations with providers.
7. The creation of a system of shared responsibilities at the local level for effective metropolitan health services promoted through guidelines and incentives from the federal government.
8. The establishment and institutionalization of linkages between the health system and other public programs such as education and social services and between the public and private sectors.
9. A role for civic action. The systematic involvement of senior citizens, churches, and grass roots organizations.
10. The recognition of the fact that since the problems to be addressed are multidimensional, responses must be comprehensive. There must also be a focus on recreating the sense of community life whose disruption has resulted in many of the urban pathologies directly and indirectly related to health status.
11. Accountability at the local level must be built upon a rational planning process, measurable goals, and concrete rewards to those communities capable of designing, implementing, and evaluating the delivery of effective health services.
12. Emphasis should be on building from the bottom up, beginning at the grass roots of the system and creating strength through partnerships, alliances, and cooperation. The guiding philosophy must be one of shared roles and responsibilities, an understanding that everyone has a role and a stake in the solution of health problems. Such a philosophy must fuel a system that is pragmatic, integrated, and cohesive.

In conclusion, as we think about access to health care and social services, I believe it would serve us well if we allowed ourselves to be guided by the essential elements of the American credo, those we teach to five- and six-year-old children when they first come to school. Since they cannot understand the full meaning of the words, we tell them to just learn them and trust us: "One nation under God, indivisible, with liberty and justice for all." "One nation" we tell them, not islands of privilege, detached from the trauma of a permanent underclass, not groups separated by indices of morbidity or degrees of suffering, not special classes defined by drug use, teenage pregnancy, or violence.

"One nation under God," a God who can see into the "shooting galleries" where young people die in agony, who can see into the home of the battered spouse or the bedroom of the abused child, who can see the anguish of the fourteen-year-old mother of an undernourished child. "One nation, under God, indivisible," not divided into black and white, not rent asunder by fear and hatred, not polarized by race or ethnicity or geography or income, not battling over a shrinking pie or paralyzed by the complexity and the inertia of the system we have created.

"One nation, under God, indivisible, with liberty and justice for all," not just for those who were born in richer states or better neighborhoods, not just those who went to the best schools, have the right name, or the preferred skin color. That is not what we teach. In addressing access to health care, one of the more complex challenges of our time, we will do best to reach back to the essence of our roots and apply, in all its strength and all its power, that American ideal.

Given the changes that are upon us, given the waves of demographic, economic, and political change that sweep across our land, we would do well to keep a steady eye on those basic and powerful tenets.

Response to Henry G. Cisneros

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Molly Joel Coye

Mayor Cisneros has described well the profile of our population in the decades ahead and the federal withdrawal from responsibility for providing access to health care. So I welcome this opportunity to note the kind of initiatives and strategies possible at the state level, albeit in a very different kind of state from Texas.

New Jersey is not only the nation's most densely populated and rapidly aging state, it is also quite possibly the most heavily regulated in many aspects of its health care system. When I joined Governor Kean as an adviser in early 1985, that system included the most rigorous hospital rate-setting system in the country and the most complete reimbursement of hospital uncompensated care. Over the last five years, we have built our strategies to balance this emphasis on cost containment with an effort to greatly enhance access to care.

Like local governments, states can also do a great deal to solve the problems of access to health care. But this is expensive, and it requires major political investment in an area that is complex, relatively arcane, and clearly has no easy answers. These factors tend to dissuade most states from confronting the issue of access head on. Instead, they more often engage in incremental steps designed to increase access for more limited segments of the population—most frequently for pregnant women and children. States also do their share, of course, of attempting to pass the buck, both up to the federal government and down to the cities and counties. Nevertheless, states are probably the most important laboratories that we can look to for information about various methods of providing access within our national borders.

As commissioner of health,* I am responsible for AIDS, cancer prevention, family planning, sexually transmitted diseases, and many other problems in addition to access to care. In states and cities, unlike the situation at the federal level, the public sector is actually the provider of last resort. As the burden of the uninsured and underinsured grows, therefore, we find increasingly that all of our resources in public health are absorbed and preempted by the task of getting our citizens to needed medical services. The necessity of providing medical care is overwhelming our traditional public health work, in areas that can ill afford it.

States have responded to the growth in medical indigency in a variety of ways, with varying degrees of comprehensiveness, and at very different paces. Some have approached it as a hospital (or provider) problem and developed strategies to reimburse for uncompensated care or to provide general budget support to hospitals, clinics, and neighborhood health centers. Other states have approached access as an insurance problem and have developed strategies to expand public or private insurance.

The most common means of expanding insurance, of course, is Medicaid expansion. But several states have gone beyond this categorical approach to attempt to provide insurance for everyone. Hawaii will come closest to this ideal next year when it closes the "insurance gap" between Medicaid eligibility and mandatory insurance for the employed which they have had since 1974. Massachusetts is still struggling with the financial difficulties that its proposal ran into. Washington state has pioneered a broad-spectrum subsidized insurance program, but this is still limited to a small portion (approximately 4 percent) of all uninsureds in the state. Most recently, New York state has proposed a sweeping plan to bring all insureds, public and private, together under a single payer authority. All of these attempts are frankly jerry-built, however, patched together to deal with the federal laws and regulations and policies referred to above. These federal restrictions are a powerful obstacle to states considering expanded roles in this area.

New Jersey's approach has belonged principally to the other camp—those states that compensate providers directly, without setting up an insurance mechanism.

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*At the time of this speech, Dr. Coye was commissioner of health for the state of New Jersey. She is currently associate professor and head of the Division of Public Health, Johns Hopkins University School of Hygiene and Public Health.

Traditionally, states and some localities have provided general funds to clinics to provide prenatal care, family planning, care for those with sexually transmitted diseases, and other personal medical services to people who do not have health insurance. Although marked by declines in the recent past, budget appropriations to public hospitals have also paid public providers for acute care for the indigent.

About a decade ago, this general (and usually inadequate) lump-sum allocation approach was replaced by direct per-patient reimbursement for uncompensated cases in several states. This, I believe, was a major improvement on the path to a rational financing system and laid the groundwork for direct per-patient purchase of insurance. Today, a decade later, New Jersey is till the only state in this country in which anyone can go to any hospital—not just public hospitals—in the state for inpatient or ambulatory care and in which the hospital will be reimbursed 100 cents on the dollar for that care. This uncompensated care system has existed since 1979. It is financed by an add-on to hospital charges. It has effectively removed the economic incentive for hospitals to discriminate against the uninsured or, to put it less elegantly, to dump patients. There is no economic basis for a two-tier system when uncompensated care is fully reimbursed.

New Jersey's system was the result of a compromise: payers would pay uncompensated care (bad debt and charity) in return for hospitals' acceptance of rate setting (all payer). Somewhat surprisingly, after almost a decade of operating this system, our rate of uninsurance is still significantly below the national average—indicating that employers have not seized on this as a reason to drop coverage.

Originally, the add-on to hospital rates was hospital specific; that is, hospitals with high rates of uncompensated care had large add-ons. But by the mid-1980s, price competition among hospitals had emerged, exacerbated by the influence of health maintenance organizations (HMOs). Hospitals with high uncompensated care rates were at a competitive disadvantage.

In 1986, therefore, we created the Uncompensated Care Trust Fund. This levied a uniform surcharge on all hospitals and created a pool—the Trust Fund—to redistribute monies. With the use of electronic banking, this system was up and running efficiently in 28 days. This is, as Mayor Cisneros described, a system that brought suburbs together with cities to support cities, without federal help. Mayor Cisneros noted the terrible economic straits of our major cities. This step was key as the finances of urban areas have rapidly deteriorated during the last four to five years—there is no way cities can do this alone.

The New Jersey uncompensated care system has provided a measurably greater degree of access for the uninsured, even though it reimburses hospitals only and does not reimburse physicians. The third national Robert Wood Johnson Foundation survey of access for the uninsured in 1986 found that access in New Jersey exceeded the national average consistently for all indicators, including those for continuity of care and frequency of ambulatory primary care visits.

The consensus supporting this system is also strong, so strong that when the federal Medicare waiver ended last year, payers, employers, and hospitals unanimously agreed to continue to operate the system as though the waiver had continued, picking up Medicare's share of uncompensated care and reimbursing hospitals where federal prospective payment system (PPS) rates were below New Jersey's diagnosis-related groups (DRGs).

But ultimately it is that very admirable desire to maintain full support at the state level that may doom us. We are forced to lean ever more heavily on large employers who insure their workers, in order to subsidize small employers who don't insure, and to subsidize the federal government, as it "rachets down" Medicare payments to solve the federal deficit.

Perhaps the strongest argument for maintaining the system—at least until we have national or state health insurance for all—is the strong public consensus in New Jersey that we cannot allow the degree of access that has been achieved to be eroded. Ten years of experience has established uncompensated care as the "moral minimum" in our state. There is a great deal of discussion about whether to shift from this system of hospital surcharges to financing by general revenues for uncompensated care, but there is no discussion at all about not paying for it.

For understandable reasons, large employers are especially interested in the switch to general revenues. So far the price tag has deterred that; uncompensated care represented about $500 million out of a total $5.5 billion industry in 1989. Similarly, when we discussed changing to an insurance approach—using uncompensated care revenues to purchase insurance—there was initially a lot of resistance. The current system costs insured employers about $150–200 per employee per year. The purchase of basic benefits for all uninsured through the uncompensated care mechanism would cost insured employers about $300.

But we have been making headway. We will be using the Uncompensated Care Trust Fund for reinsurance to make insurance more affordable to small employers and to subsidize dependent coverage. Our Medicaid expense program for pregnant women and infants, HealthStart, is the only one in the country to offer the full range of recommended services, case management for all families, and coverage for all women and infants, not just those at medical high risk.

When the new recommendations came out this spring and summer for early intervention and treatment of HIV-infected persons, New Jersey became the first (and so far the only) state to organize and offer these services to all HIV-infected persons in the state.

In other words, the uncompensated care experiment has not only provided inpatient and ambulatory care access for the uninsured in New Jersey, it has also laid the philosophic basis for full and equal access to public health and medical services as they are developed.

The Oregon Model

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John A. Kitzhaber

In 1968 Dr. Garrett Hardin wrote the classic essay "The Tragedy of the Commons" in which he described a common pastureland in an English village on which any villager has an unrestricted right to put as many animals as he wants. Whatever benefit comes of that—milk, beef, hides—belongs to him as private property. In other words, the individual can derive private benefit from the use of common property without necessarily having to give anything in return. The tragedy of this arrangement is that it is built on the false assumption that the carrying capacity of the commons is infinite. It also encourages the individual to concentrate solely on his own benefits and to ignore the cost that makes those benefits possible. And because it provides every incentive for the individual to profit from a common resource, and no incentive for him to contribute to its maintenance, it encourages abuse. From its inception, therefore, this idealistic system is on the road to ruin, because it "privatizes" profit while it "commonizes" cost.

That is an apt analogy for what is happening in our health care system. We have created a system based on the illusion of "fee" care in which we have been able to "commonize" costs while "privatizing" benefits. With the enactment of Medicare and Medicaid in 1965, and with the growth of private insurance policies, most Americans until recently had access to third-party insurance coverage. Because of a fee-for-service reimbursement system, those who were not covered were still treated and the cost simply shifted to someone who could pay, by increasing either their premiums or their bills. The effect was to insulate both providers and consumers from the true cost of treatment decisions, giving the illusion that health care was nearly free. This arrangement encouraged individuals to expect access not only to the health care system but to everything the system had to offer. It allowed providers to carry out to the fullest the tenets of the Hippocratic Oath: *I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients.* They enjoyed the luxury of employing all treatments available, regardless of their cost, as long as some benefit, however slight, accrued to the patient. The result of cost shifting and third-party insurance coverage was that public expectations and practice patterns were disconnected from the economics of funding them.

While this appears to be an ideal arrangement from the standpoint of access and treatment, it is at best a curious economic arrangement. Is it not curious that physicians in America can order any test, any procedure, any therapy that might possibly benefit their patients, regardless of the cost and regardless of the patient's income—and still expect that these services will be performed and that their fees will be paid? Is it not curious that in America individuals can expect access to as much care as they need (or want), including all new technologies, regardless of the cost and even if they cannot pay for it—and still expect that it will be provided? There is no other part of our economic system that operates this way. It would be like an automobile mechanic accepting any car regardless of the owner's income, doing whatever was necessary to make the car work, and expecting everything to be paid for. Obviously there are no mechanics who operate on this basis, and yet that is how we finance health care in America.

Like Dr. Hardin's commons, which served very well as long as there were not too many people trying to benefit from it, our health care system served very well as long as the costs were not excessive. That was the case in the 1960s. It is not so today. Public expectations, legal liability, and professional ethics have encouraged the use of all available tests and procedures—even those that are of marginal or unproven benefit—as long as the bare possibility of some benefit exists. For example, it has been estimated that well over 50 percent of intensive care unit costs are expended on nonsurvivors and that over one-third of all health care in America is provided to people over the age of 65, 30 percent of that in the last year of life. With the development of new technologies and with the aging of the population, therefore, more and more resources have been allocated to health care. In 1950 we spent about $12 billion per year on health care. In

1970 that had grown to $75 billion and by 1980 to almost $250 billion. Today that expenditure is over $600 billion and is expected to top $1 trillion by the year 2000. Health care expenditures, which consume over $1.5 billion per day in 1990, are growing at over twice the rate of growth in the rest of the economy.

As health care costs continued to increase, and as federal deficit spending grew more pronounced, investments in other areas of our society began to diminish. Alain Enthoven has pointed out that in 1970 we spent two dollars on defense and education for every dollar we spent on health care. In 1990, however, health care spending exceeds the total amount spent on education and defense combined. We have become obsessed with health *care* as opposed to actually improving *health.* There is no question that the American medical system is unsurpassed in the treatment of disease and injury. There is also no question but that the American system favors intervention over prevention. At present the United States spends a mere 0.5 percent of the medical budget on prevention that could eliminate some of the diseases currently treated with surgical and medical technology. That is, investments in health care do not have nearly the benefit in terms of the overall health of the population as do investments in such areas such as the environment, education, housing, nutrition, or economic opportunity. We tend to downplay prevention and to glorify technology and intervention. We tend to treat symptoms as opposed to causes. And many of the medical problems treated today in our health care system—such as substance abuse and violence—have social not medical causes. Yet as total health care costs continue to increase, it becomes more and more difficult to make significant investment in these other areas. We continue to treat the medical complications of drug abuse, for example, while we fail to address the social conditions that lead to addiction in the first place. And so, paradoxically, the very existence of a bloated health care budget actually hinders the effort to improve the health of the nation.

The system we created in the 1960s and 1970s encouraged dramatic and unchecked escalation in costs by hiding them from both patients and providers—from those receiving the treatment and from those giving the treatment. Nobody wants to pay the costs explicitly, yet nobody want to say "no" to the individual patient. Providers consider it a violation of professional ethics to refuse treatment, patients consider it a violation of their entitlement, and the plaintiff's bar is there to enforce the status quo. So while care seemed to be "free" and while there were few real barriers to either access or treatment, there was, in fact, a tremendous cost being shifted to the government and to employers. The cost of Medicaid and Medicare and the cost of private insurance premiums increased dramatically. The result was that the payers, who could no longer absorb these astronomical increases, devised ways to reduce their exposure to them. Although neither public nor private insurers have ever publicly rejected the principle of universal access—in fact, they still pay lip service to it—their actions have had the very real effect of creating enormous barriers of access for a substantial part of our population. Their actions, taken in the name of cost containment, neither contained costs nor stemmed public expectations. The costs were simply shifted back onto providers and consumers while expenditures continued to escalate.

In 1983 the federal government enacted the Diagnosis-Related Group (DRG) program (which shifted costs and economic risks to providers), added first-day hospital deductibles for Medicare, and raised Medicare Part B premiums, shifting costs to individuals. States changed Medicaid eligibility standards, in effect "redefining the poor" for accounting purposes, throwing people off the program to balance the budget and so shifting costs to individuals. Nationally, the average Medicaid eligibility is set at less that 50 percent of the federal poverty level, which means that a family of three making more than $4,800 per year is considered too wealthy to qualify for state medical assistance in many parts of the country.

States have also reacted by cutting provider reimbursement rates so drastically that many providers are refusing to see Medicaid recipients. Those who do continue to treat the poor often shift the uncompensated costs to employers, driving up their insurance premiums. Businesses have reacted by contracting with the health maintenance organizations (HMOs) and preferred provider organizations (PPOs), shifting costs and risks to providers, and have added copayments and deductibles, and have increased employee contributions, shifting costs to individuals.

Those employers who continue to provide coverage for their workers find themselves paying not only for that coverage but also, through higher premiums caused by cost shifting, for under-reimbursement in the public sector and for the costs incurred by workers who do not receive health care coverage through the workplace. Some of these employers have been forced to drop dependent coverage or to drop coverage altogether.

These events have made cost shifting increasingly difficult. On an individual basis we are uncomfortable not doing "everything" we can for patients. On a social basis we are unwilling to pay for it. The growing costs remain implicit at the point of delivery only for those with insurance coverage—and even then many find themselves "underinsured." For those without coverage, the costs are now explicit and, if they do not have the resources to pay for them, the uninsured are increasingly likely to lose access to the system either because a provider refuses to see them or because they delay or avoid seeking treatment out of concern for how to pay for it. The result is the rationing of people in America. It is rationing that occurs implicitly, arbitrarily, and by default in a country that spends more per capita and in aggregate on health care than any other nation in the world. It is rationing unguided by any social policy, rationing for which there is no accountability for the consequences. It reflects neither social values nor ethical principles and does not consider clinical effectiveness.

To date, most of the efforts to address the problem of access and cost have taken one of two general forms: either to attempt to get more money into the system or simply to mandate additional benefit coverage. The first approach fails to address the problem of overutilization, and it fails to examine the value of effectiveness of the services being purchased. It simply institutionalizes the status quo along with its costs and inequities. The second approach is just another form of cost shifting. Neither approach recognizes the reality of limits and neither speaks to the need for an overall health strategy that reflects a clear policy of balanced allocation between health care and such crucially related issues as the environment, education, housing, and other social concerns that have a profound impact on health.

A prime example of the first approach is embodied in *Health Policy Agenda for the American People,* underwritten by the American Medical Association and released in 1987. The report made a number of recommendations which, if fully implemented, would unquestionably improve access to health care in America—at least in the short run. The cost of implementation, however, would range anywhere from $13 billion to $28 billion. This enormous spread would depend on whether a minimal or "basic" package of benefits was provided (as in Washington state) or whether a full or "comprehensive" benefit package was provided (as in Minnesota).

While I agree with many of the proposals in *Health Policy Agenda for the American People,* I see at least two crippling defects in it. First, it doesn't say where the $13 billion to $28 billion is going to come from. In the era of Gramm-Rudmann budgeting, this is a critical shortcoming if our objective is to actually *achieve* universal access, as opposed to just talking about it. Second, the proposal says nothing of how society decides or develops a consensus on what constitutes a "basic" as opposed to a "comprehensive" package. Again, this is a serious flaw. It is easy to talk about "basic" benefits if you don't have to talk explicitly about those services and procedures that go *beyond* the definition of "basic." A discussion of basic benefits that does not also include a proposal for defining "basic" is, from a practical standpoint, useless.

The second method of dealing with the problem of access is to mandate coverage for specific services. This classic federal approach, favored by the congressional Subcommittee on Health and Environment, which has exclusive jurisdiction over the Medicaid program, is actually just another form of cost shifting and an especially irresponsible one at that.

The approach is fine in theory, but it ignores the inescapable relationship between cost and access. When the federal government mandates additional services on the Medicaid program, states are forced to try to come up with large amounts of new revenue. But mandating health services does not in itself necessarily produce any more money and can have a devastating effect on state budgets, in which health care dollars must compete with dollars to fund public education, corrections, and a host of other essential social programs. If the states (which, unlike the federal government, must operate within the constraints of a balanced budget) are unable to generate enough new revenue, they are often forced to respond by changing Medicaid eligibility levels, by further reducing provider reimbursement, or by underfunding other programs, many of which also may have a significant effect on health. The new mandates, while laudable if viewed in the narrow context, not only assume that all health services are of equal value and effectiveness, but ignore the fact that in addition to receiving health care, our children, for example, also need a clean environment, houses in which to live, schools in which to be educated, the hope for an economically secure future, and a home environment in which they will be loved and nurtured, not abused and neglected.

The practical result of federal mandates then is an improved benefit package for some—the steadily shrinking number of those who are able to qualify for Medicaid—at the expense of denying access for many others. In addition, when the federal government imposes these mandates, it ignores the problem of cost escalation and avoids assuming any social responsibility for the clear need to balance various areas of investment.

So much of background—necessary, I believe, if we are to see the problem of access to health care in true perspective. In Oregon we have embarked on an innovative course of action that we think holds great promise for dealing realistically and effectively with this enormous problem. The plan is embodied in legislation passed last year by the Oregon Legislative Assembly, and implementation is already under way, although a federal Medicaid waiver must still be obtained.

The Oregon model removes, to the extent possible at the state level, the implicit subsidies of the current system and replaces them with explicit subsidies based on a clear public policy. It guarantees access to a basic level of health care for all Oregonians and provides economic incentives to providers for employing those services and procedures that are effective and appropriate in preference to those that are marginal or unproven. It also establishes an allocation process that allows appropriations to the health care budget to be balanced with appropriations to other budgets that may have a significant impact on health itself. The Oregon model is based on the following principles:

1. There must be universal access for the state's citizens to a basic level of health care.
2. There must be a process to determine what constitutes a "basic" level of care.
3. The criteria used in this process must be publicly debated, must reflect social values, and must consider the common good of society.
4. It is the obligation of society to provide sufficient resources to finance a basic level of care for those who cannot pay for it themselves.
5. The health care distribution system must offer incentives to use those services and procedures that are effective and appropriate rather than those that are of marginal or unproven benefit.
6. The distribution system must avoid creating incentives for overtreatment.
7. Funding must be explicit and the system must be economically sustainable.
8. Allocations for health care must be part of a broader allocation policy that recognizes that health can only be maintained if investments in a number of related areas are balanced.

The centerpiece of the plan, Senate Bill 27, defines the population for whose health care the state is responsible as all those with a family income below the federal poverty level. The private sector (through an employer mandate) is responsible for the health care of those earning above that level.

Once the state's share of the population is defined, the state is statutorily prohibited from redefining it in order to balance the budget. As a matter of law, then, Oregon has said that everyone is guaranteed access to the health care system—*universal access.* Those with a family income below the federal poverty level are guaranteed access to the state Medicaid program; those with a family income above that level are guaranteed access to an employment-based policy *that must provide a benefit level equal to or greater than that offered by the state for those on Medicaid.* What we have done is to change the debate from *who* is covered to *what* is covered. We have recommitted ourselves to the principle of universal access and, having done so, have developed a public process to determine what all Oregonians will have access to. The process used to make this determination—to define the benefit level—differs significantly from the current process of federal mandates and piecemeal state insurance mandates based on the relative political power of special interests. Rather, the benefit level will be based both on social values and on what makes sense clinically in terms of improving health.

Since this clinically based benefit package must be constructed within the context of limited resources, the bill establishes a Health Services Commission (HSC) comprised of both providers and consumers. The current commissioners, who were appointed by the governor and confirmed by the Senate after public hearings, include four medical doctors, one doctor of osteopathy, one social worker, one public health nurse, and four consumers. The commission will prioritize health services using criteria based on social values and, within the context of those social values, according to the degree of benefit each service or procedure can be expected to have on the health of the entire population being served, starting with those services and procedures that are most beneficial and moving down to those with a lesser benefit in improving health.

Because to my knowledge this is the first time that an attempt has been made to formally incorporate both social values and clinical effectiveness into the health care delivery system, it is important to understand this approach. There are two main elements to the prioritization process: the determination of social values and the determination of clinical effectiveness. Let us look at each in turn.

To determine social values, the HSC is using the Quality of Well-being (QWB) scale developed by Robert M. Kaplan (at the University of California at San Diego) and others. The QWB scale seeks to measure the important criteria of health-related quality of life—that is, the value society puts on the prevention of death or on the alleviation of a variety of symptoms such as pain, stiffness, depression, visual problems, fatigue, weakness, and the like. The QWB scale, which has been empirically validated and shown to have a high degree of accuracy and descriptive reliability when measuring dysfunction, provides the necessary tools to integrate social values with medical experience. It is easily administered and for the Oregon model the questionnaire has been rewritten to a sixth-grade reading level.

The scale will be modified with Oregon-specific values through a random sample telephone survey and by a site-specific personal survey to determine the values of those persons in special categories (such as the economically and educationally disadvantaged, the bedridden, and the chronically depressed). Additionally, social values are being elicited from persons attending 50 publicized community meetings now being held around the state.

To determine clinical effectiveness, the HSC will use two widely recognized classifications of treatment and diagnosis. One is the *Physicians' Current Procedural Terminology* (CPT codes), which is an extensive listing of various medical procedures published by the American Medical Association. The other is the *International Classification of Diseases* (ICD codes), which is a comprehensive listing of diagnoses. These CPT and ICD codes will be categorized into related procedures and diagnoses in the interest of simplicity, and the commission will look at "procedure by diagnosis." So, for example, if the procedure is "abdominal hysterectomy," the diagnosis for which it might be indicated could include endometrial cancer, cervical cancer, uterine bleeding, or fibroids.

A number of factual judgments will be made about each CPT/ICD code category, including (1) the probability that the procedure will be successful, (2) the average health benefit of successful treatment, (3) the average duration of the health benefit for successful treatment, (4) the cost of the procedure, and (5) additional ongoing symptoms and costs that may result form the initial procedure. (For example, ablation of thyroid tissue to treat hyperthyroidism may result in hypothyroidism and the need for ongoing thyroid hormone replacement therapy.) This information will be provided by panels of health care providers, the members of which practice in the specialty area of each CPT/ICD code category (such as pediatrics, general surgery, primary care, nephrology, obstetrics). An exhaustive review of medical journals will be undertaken to obtain whatever empirical information may not exist and, in those areas where such information is not available, the judgments of the panel of experts will be used.

In determining the final prioritization list of health services, the benefit/cost ratios for each CPT/ICD code category will be considered. Benefits will be measured in terms of quality-adjusted life years (QALYs), which will take into account the estimated average improvement in QWB and the estimated average number of years over which that improvement extends. Cost will be the estimated average cost in Oregon for the procedure.

The completed priority list will be given to an independent actuarial firm, which will determine the cost of delivering each element on the list through managed care. The list, along with the actuarial data, will then be given to the legislature, which *cannot* alter the order of the priorities established by the HSC. The legislature must provide the same package of benefits to all those in the statutorily defined population, starting at the top of the priority list and working down as far as available revenue will allow.

When existing revenue has been exhausted, a debate will clearly ensue about those services on the margin. But, in reality, this is a debate we currently have over the health care budget every year. At present, however, when we have exhausted available revenue, we don't objectively evaluate the benefit level in terms of effectiveness or of priority based on social values. Rather we simply reduce provider reimbursement (creating a disincentive to offer access) or change eligibility so as to drop people from coverage altogether.

Under the new program, the state can no longer arbitrarily change eligibility for reasons of budgetary expediency. Everyone retains coverage. The debate centers on the *level* of that coverage—on what we as a society feel is "adequate," on what level of health care we as a society are willing actually to fund and thus guarantee to all of our citizens. It forces us to define the common good and to clarify the social contract as it relates to health care. Because, ultimately, the socially acceptable minimum level of care is what society is willing to pay for.

This process makes that reality explicit and creates a situation that will unquestionably result in a higher funding level. It is very easy to cut provider reimbursement or to change eligibility because the results in terms of restricted access are not readily apparent to those making the decisions. But once everyone, regardless of income, is covered and the option of rationing people no longer exists, the politics are significantly changed. The public debate centers on *specific* additional appropriations for *specific* services that will benefit *all* Oregonians. In addition, the appropriation decision and the public debate will be assisted by the availability of information concerning the value society puts on the service as well as on its effectiveness. So while the state can certainly allocate more money to the health care budget—and Oregon intends to do so—it can no longer arbitrarily redefine the poor by changing eligibility or cut provider reimbursement below cost in order to balance the budget. The choice is explicit—a matter of social priorities—and accountability is inescapable.

This process also forces society to view health care expenditures in the context of overall appropriations—that is, to balance health care spending with spending in other areas. Since funding for health care is explicit, we will know exactly what is being purchased. If a higher benefit level is desired, it will be very clear that this can only be achieved by increasing taxes or by taking money away from other budgets. If the former course is chosen, the tax debate becomes more focused. Instead of more money for "government," the argument will focus on new revenue to purchase specific health services. If the latter course is chosen, the value of the service being funded must be balanced against the impact of underfunding something else such as education, housing projects, or investments in sewer and water systems. This process will force society to develop an overall health policy in which resources are balanced.

Once this level of care has been determined by the state, employers are required to make at least this same level of care available to all those with a family income above the federal poverty level. Thus we have defined the entitlement, the level of care to which all Oregonians are guaranteed access: *universal access to a basic level of care.* And because the basic level of care is determined through the prioritization process of the Medicaid program, all Oregonians have a stake in ensuring that the Medicaid benefit level is as comprehensive as the state's resources will allow.

When a consensus has been reached on the funding level—that is, on the amount of revenue that can be allocated to the health care budget as opposed to other budgets that must also be funded—the state will enter into managed care contracts with providers to offer this package of benefits, at the actuarily determined reimbursement rate, for a one-year contract period.

A very significant element of the bill provides a "liability shield" for providers—a statutory distinction between actual medical malpractice, and not providing a service that society has determined not to fund. This sets an important precedent that will be critical if we are to establish practice standards or guidelines based on effectiveness and appropriateness and not increase providers' exposure to lawsuits.

The Oregon Basic Health Services Act begins to address realistically the problems of access and cost in our health care system. It guarantees universal access to a basic level of care and includes a public process to determine what should be included in that "basic" level. The services included in the basic package reflect both social values and clinical effectiveness. The criteria used in the process are arrived at through public debate and must include a consideration of the overall social good. Incentives are included to minimize overutilization and to favor those health services that are effective over those that are marginal or unproven. In addition, the program clarifies the appropriate role of providers and of society in the area of health care. Society has the clear responsibility to determine the level of funding that will be committed to health care as opposed to other areas that also need investment. Providers have the responsibility to aid society in making that determination by providing reliable information on what is effective and appropriate and to continue to be patient advocates within the context of the resources that society has made available. Finally, the Oregon Basic Health Services Act forces society to develop a broad allocation policy in which expenditures on health care are balanced with expenditures in areas that may have a profound impact on health.

Oregon is pioneering the way in honestly facing the issue of limits, in forcing society to make explicit resource allocation decisions, and in developing a clear and equitable public policy to guarantee access to a health care system based on effectiveness and social values. We recognize, however, that we are confronting an issue that cannot be resolved on a state-by-state basis. A national solution is needed. For example, the Oregon proposal does not address the issues of part-time or seasonal workers, many of whom are migrant. That can only be done by a national approach with an insurance pool that covers these individuals as they move from state to state. Nor does the Oregon proposal address the problem of the huge administrative costs of the current system, a task that can only be undertaken at the national level. We have, however, made a start.

In spite of the need to adopt a national approach, I do not believe that definitive federal action is likely in the near future. The full-scale retreat on the issue of catastrophic care suggests that Congress is not yet willing to address the real issues underlying this crisis—the reality of limits and the need to define the entitlement. I believe that before federal action occurs, someone has to demonstrate that the politics of the solution are not, in fact, insurmountable and that the entitlement can be defined be forging a partnership of the public, the policymakers in the legislature, and the medical community.

Let me close by saying that in order to face the health care challenges of the 1990s it is my profound belief that we must determine and focus on the common good. In order to avoid the "tragedy of the commons," for which we are surely headed, we must resolve to abandon piecemeal approaches and develop a comprehensive policy that honestly recognizes our social and fiscal limitations and that addresses the real underlying problems of the current system. We must be guided by principle, not by emotionalism. We must reject what is politically expedient and do what is right.

Response to John A. Kitzhaber

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Kenneth W. Kizer

Good evening. I would like to join Dr. Thier in commending and thanking the Rosenthals and the Rosenthal Foundation for making this forum possible.

I am pleased to be here tonight to respond to Dr. Kitzhaber and to make some comments about the health access proposal being developed in Oregon. As a former Oregonian and as a sometimes practicing emergency physician, it is a special pleasure to share the podium with Dr. Kitzhaber.

At the outset, I would like to commend Dr. Kitzhaber for his articulate and cogent presentation. I commend him for tackling a very sensitive and complex issue in a generally open and forthright manner. In doing so, he has exercised a degree of political courage not often seen in elected officials today.

There are several issues underlying the Oregon proposal about which I agree with Dr. Kitzhaber. For example, I agree with him that universal access to at least basic health care should be the operative norm of our health care system. Likewise, despite the number of calls in recent years for a national solution to the access/cost control/quality health care paradox, I do not see such happening in the near future. The essentiality of reducing the federal budget deficit, preoccupation with other issues, and, to date, the lack of national political will or consensus about major health care system reform all militate against the likelihood of major federal action to revamp the health care system any time soon. Instead, for the next several years, I see states fashioning solutions that are fiscally, socially, and politically suited to their populations. And while the approach outlined by Dr. Kitzhaber may be suitable to Oregonians, I do not think that it would be palatable in California.

I also agree with Dr. Kitzhaber that there is a great need to view health care in more realistic economic terms, as well as a need for open public debate about health care within this context. In this vein, I agree with Dr. Kitzhaber about the need to set health care priorities.

Setting priorities is essential to the management of any activity for which resources are scarce relative to demand. Unfortunately, as we all know, establishment of health care priorities has never occurred in a systematic way in the United States, nor has a national health care strategy ever been promulgated. We need to set health care priorities for our limited public health care resources, and, in the absence of national action in this regard, it is up to the states to actively pursue this. For example, California has given high importance to expanding access to prenatal care in the past several years. This has been one of my highest priorities as director of the California Department of Health Services, and I should take a few moments to mention some of our actions in this regard.

In the last three years, California has expanded Medi-Cal eligibility for maternity care and medical care of infants to 200 percent of the federal poverty level. I believe we lead the nation in this regard at this time. Similarly, Medi-Cal obstetrical reimbursement rates have more than doubled since July 1986, rising from $520 to $1,073 for global antepartum, delivery, and postpartum care. Also, recently enacted legislation has equalized reimbursement rates for vaginal and cesarean deliveries.

California has initiated multiple administrative actions to improve provider relations with obstetrical providers and thereby increase Medi-Cal obstetrical access. In addition, California has initiated the comprehensive Perinatal Services Program, which provides nutrition, psychosocial, health education, and coordination services to Medi-Cal women, over and above traditional obstetrical services, and has established financial incentives to encourage participation in this program.

A number of other special programs have been implemented, ranging from the Prenatal Care Guidance Program, which assists Medi-Cal women in obtaining and continuing perinatal care, to the California Diabetes and Pregnancy Program, which provides specialized services for pregnant diabetics. This program is now being replicated in many other states. Several pilot projects for drug-using pregnant women are also in the development stages.

Unfortunately, time does not allow a detailed discussion of these or other actions, but it is of interest that in our just completed review of California's 1988 vital statistics the infant mortality rate dropped to its lowest point ever and to the lowest rate of the ten largest states. After remaining stable at around 9 deaths per 1,000 live births for several years, it dropped to 8.6 in 1988. Obviously, it is not possible to scientifically attribute this drop to the actions we have taken to enhance perinatal care, but the figures at least suggest that such actions are having a positive effect.

Having said this, let me turn to my concerns about the Oregon model. First, though, it is relevant to note that in any health care insurance program, of which Medicaid is one, costs or expenditures are a function of four interrelated variables:

- eligibility, or who is covered;
- benefits, or what services are provided;
- reimbursement rates, or what is paid for services; and
- utilization of covered services, or how often services are used.

I am concerned that the Oregon model seems to be trying to control expenditures primarily through limiting benefits. Although services are to be provided through managed care programs—*if* such are available—little attention seems to be focused on service utilization, an area that could potentially save substantial amounts of money that, in turn, could be used to increase benefits. This is of particular concern in view of recent studies that have shown notable overutilization of commonly provided services. For example, studies have shown that 56 percent of cardiac pacemakers, 44 percent of coronary artery bypass graft surgeries, 64 percent of carotid endarterectomies, 24 percent of angiographies, and 21 percent of pediatric hospital days were for equivocal or inappropriate reasons. Similarly, studies have shown substantial overutilization of laboratory and other diagnostic procedures. The Oregon model does not seem to adequately address concerns about overutilization of services.

Similarly, I understand that in the proposed Oregon model reimbursement will be for "allowable costs," but "allowable costs" are not defined and—depending on how such are defined—may not encourage efficient use of resources. I suspect it is safe to say that "allowable costs" are not the same as Medi-Cal's Maximum Allowable Benefits Schedule.

It is not clear why, in the Oregon model, the state is not also pursuing utilization control efforts such as hospital contracting or establishment of a Medicaid drug formulary. I suspect that expenditures for drugs is an area of rapidly increasing Medicaid expenditures in Oregon, just as it is in California and many other states.

For example, in California, with our rather restrictive Medi-Cal drug formulary, from fiscal year 1983–84 through fiscal year 1989–90 (projected), outpatient prescription drug expenditures will have risen 165 percent, compared to an increase of 74 percent for all other fee-for-service expenditures. To put this in real dollars, drug expenditures will have increased from $217 million in 1983–84 to $576 million in fiscal year 1989–90 (projected). And we project an increase of another $50 million in the next fiscal year.

It is also unclear why Oregon proposes to limit, or ration, services only for its AFDC population, the lowest cost-per-user population covered by Medicaid and the population—from an overall public health perspective—that may benefit the most from health care services. There appear to be some substantive unresolved operational issues in this approach, as well as some moral and ethical concerns.

Similarly, it is unclear how a benefit package that potentially changes each year will affect persons with illnesses that transcend budget years. That is, what happens to people receiving services when the benefits get reduced in a new, leaner budget? Since obtaining increased revenue to cover dropped services requires an act of the legislature or the electorate, this may not be timely from the ill person's perspective.

Also, how does this approach work in the long term when the medical care price index is increasing at twice the rate of the consumer price index? Does this not mean that there will be fewer and fewer benefits in the long term, since with these economic dynamics revenues will never keep up with expenditures? The politics of the first case that falls through the cracks will be interesting, to say the least.

Similarly, the meaning and implementation of the proposed liability shield is unclear. Does it mean that the tort system gets suspended? There are also questions about the employer mandate and risk pool aspects of the model. For example, is not the risk pool underfunded from the outset?

Whether the Health Care Financing Administration approves Oregon's Medicaid waiver request and whether the Oregon model ever gets fully implemented remain to be seen. However, the access/cost control/quality paradox must be addressed. And while the Oregon model is certainly of interest, I believe that a broader approach is needed.

Yes, we need to set priorities, but we also must focus more explicitly on utilization control, increasing private insurance options, and increasing revenues for health-related programs. We must recognize the fact that disproportionate health care inflation will continue for the foreseeable future and that we are going to have to invest substantially more dollars into the health care system if there is to be true equity and universal access. At the same time, though, we have to recognize the constraints and limitations of state general funds, as well as federal funds, and begin to tap into alternative sources of revenue—especially those things that have adverse health consequences such as smoking, alcohol use, and traffic violations, to name a few.

A good example of these alternative revenue options is Proposition 99, passed here in California in November 1988. This measure levies a 25 cents per pack "user fee" on cigarettes. This measure will put about $1.4 billion into California's health care system during the next 18 months.

Other points could be discussed here, but suffice it to say that California has many of the same problems as Oregon, and we will be watching with great interest as Oregon's approach further evolves, and as we pursue a somewhat different course.

Contributors

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