



ACCOUNTABLE
HEALTH CARE:

Is it compatible with social solidarity?

Uwe E Reinhardt, PhD



Annual Lecture 1997

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ISBN 1899 040 307
February 1998

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I INTRODUCTION

If a dart were thrown at a map of the world and one identified the national capital nearest the dart, the following would be a safe prediction: somewhere in that capital a task force is busily at work on yet another a blueprint for health-care reform. The prediction is safe because, at any time, in any nation, there is widespread malaise over that nation's health system. Furthermore, the alleged shortcomings of the current system are everywhere the same.

Those who book health spending as an expense believe that the system could and should deliver much more 'value' for the money. In the United States one speaks bluntly about the widespread 'waste, fraud and abuse' in the system. Germans, ever eager not to offend, more delicately call it *Wirtschaftsreserven* (economic reserves). The British speak of 'inefficiency'.

Juxtaposed to those who lament waste and abuse stand physicians and other providers of health care – those who book health spending as income. These providers¹ feel underfunded and unappreciated, for they are paid so much less than the enormous value they believe they create.² They hold out the promise of even greater value, were they more generously funded.

Remarkably, the allegations of waste, on the one hand, and of underpayment, on the other, seem independent of the actual level of national health spending. We hear these complaints in the United States, which spends over 14 per cent of its gross domestic product

1. Physicians often bristle at being labelled 'providers of care'. They preferred to be thought of as healers who care for their patients with the support of others in the health system. The term provider is used here merely as shorthand notation for physicians, employees of hospitals, pharmacists, other health professionals and the owners and employees of industries that supply other goods and services going into the treatment of patients.
2. Unbeknownst apparently to many medical workers, shortfalls between the value goods and services create for clients and the revenue received by suppliers of these goods and services are endemic in a market economy. It occurs in all economic sectors. Economists call these shortfalls the 'consumers' or buyers' surplus'.

Figure 1 **National Health spending as a per cent of GDP**
Selected countries, 1996



Source: Anderson (1997), Exhibit 1, p.164.

(GDP) on health care (see Figure 1); but we also hear them in the United Kingdom, which spends a pittance by American standards (less than 7 per cent of GDP). We hear them in Canada and all over the European continent, where spending levels mostly range between 8 to 10 per cent of GDP, and we even hear them in the Asian nations, whose health spending still tends to be below both European and American standards. The malaise over health care seems a permanent part of the human condition.

The sources of this perennial malaise are explored in Section II, where it is proposed that, try as we might, we shall never escape from that malaise. The idea that 'the market' could extricate us elegantly and 'efficiently' from our problems appeals more at the level of abstract theory than where the proverbial rubber hits the road, because the general public finds it so difficult to live with the harsh distributive ethic embedded in applied market theory.

Indeed, as I shall argue in Section III, the term 'efficiency' itself has meaning only relative to a well defined goal. A prominent dimension of the goal one might posit for a health system surely is the distributive ethic that system is to observe. Because market-driven health systems

typically are not oriented toward the egalitarian ethic that is being pursued by, say, the British National Health Service or the government-run Canadian health-insurance system, one cannot compare market-driven health systems with these government-run systems in terms of their relative 'efficiency'. Although that point should be obvious to any thoughtful person, it is overlooked with distressing regularity in the debate on health policy.

After considering the contribution of 'managed care' to greater accountability on the part of providers in Section IV, I shall turn to a review of the elegant theory of 'managed competition' and its so much less elegant current practice in the United States in Section V. I shall then ruminate in Section VI on the oddity that so many Americans now judge the American health system fit for export to the rest of the world, in spite of the manifest misgivings Americans themselves voice over that system. Even more mysterious is the widespread acceptance of that judgement in many other parts of the world.

In Section VII, I shall offer some commentary on health policy in the United Kingdom, albeit rather bashfully, as the mixed performance of the American health system hardly furnishes an American with a robust platform from which to preach to the rest of the world.

The essay concludes, in Section VIII, with a broad review of the three distinct reform models that now vie for the policy maker's favor everywhere – models that distinguish themselves from one another mainly by the role they would assign to the recipient of health care and by the allocation of the fiscal burden of illness among members of society.

II THE PERENNIAL MALAISE OVER HEALTH CARE

On the surface, the perennial malaise over health care seems a paradox. Modern medicine is an inexhaustible source of new miracles that create life where none would otherwise have come about, that can prolong life where death had been inevitable, and that can restore good quality to lives that would otherwise have been desperate. A Martian might be forgiven for seeing in modern health care a source of human pride and joy. Instead, frustration reigns.

This frustration will never vanish, because the transactions between those who receive health care and those who render it lack the economic legitimacy that underlies most other exchanges of favors among members of society. There are at least three reasons for this lack of economic legitimacy.

Vanishing trust

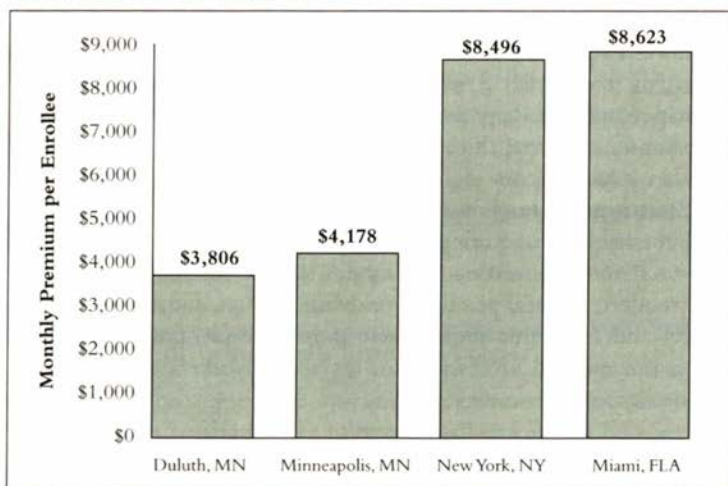
First, those who provide health care generally understand its intrinsic qualities much better than those who receive it. Only devout economic theorists pretend that patients typically can assess the merit of the treatments recommended to them by physicians and that patients can engage in the benefit-cost tests that legitimize the exchange of normal goods and services. This asymmetry of information requires patients to have trust in the professionalism of physicians. Patients must assume that (a) physicians know what they are doing when they recommend particular medical treatments and (b) physicians invariably will rise above any personal economic conflict of interest in making those recommendations.

Is that trust actually warranted? Can patients safely assume that physicians invariably know what they are doing when they compose their recommended treatments? It turns out that, even if physicians always did act as faithful agents of their ignorant patients, their recommendations would still lack economic legitimacy, because the medical profession itself does not always agree on the relative clinical merits of alternative interventions, let alone on their relative economic merits³.

3. In that respect, physicians resemble no one as much as economists whose scholarly grasp of economic processes, impressive as it may seem, still leaves large lacunae of ignorance. Like physicians, economists proceed as much on educated hunches (or on personal preferences) as they do on solidly tested economic theory when they offer their policy prescriptions.

Extensive research during the past two decades has unearthed large, inexplicable variations in the per-capita use rates of particular medical procedures and, consequently, of total per-capita health spending. These variations had been discovered in long ago France (see, for example, Roesch and Laugier, 1957). They also have been noted in other parts of Europe and Canada (McPherson *et al.*, 1982; Roos and Roos, 1981) and, of course, in the United States (Wennberg and Gittlesohn, 1982; Welch *et al.*, 1993). John E. Wennberg, the pioneer of this type of research in the United States, has recently published with his associates the *Dartmouth Atlas of Health Care in the United States* (Wennberg and Cooper, 1998). That volume extends his earlier studies to all counties of the United States.⁴ Figure 2, taken from the *Dartmouth Atlas*, illustrates how much more tax money health-care providers in Miami, Florida and in New York City extract from the federally funded Medicare program for the elderly, per Medicare beneficiary, than do physicians in Minnesota. In fact, the overall variation in risk- and price-adjusted per-capita spending per Medicare beneficiary among counties

Figure 2 **Estimated average adjusted per capita cost (AAPCC)* Per Medicare enrollee, 1997**



Source: John E Wennberg *et al.*, *The Dartmouth Atlas of Health Care 1998*

*Adjusted for differences in age, gender and other illness-related factors

4. For regularly updated information of these geographic medical-practice variations, visit the website www.dartmouth.edu/~atlas/.

in the United States is even wider than that illustrated with Figure 2. This enormous intra-US variation dwarfs cross-national variations within the industrialized nations! Depending on where one resides in the United States, health spending as a percentage of the GDP ranges anywhere from the British level to probably thrice the British level. How can physicians, who obligate the bulk of health spending in a modern health system, justify these enormous variations?

So far the most compelling answer has been that 'medicine is as much an art as a science' and that these variations reflect the vague something called 'preferred practice styles', which is code for 'firmly held but untested medical theories about how best to respond to a given body of diagnostic information'. In the high variance of these 'preferred practice styles' lies the impetus for the current worldwide quest for 'evidence-based medicine' (Sackett, 1996). That quest is an attempt to base the practice of medicine on more rigorously tested medical theories. In these observed practice variations, however, also lies the impetus for the much more controversial concept of 'managed care', which is the idea to proctor externally and, if necessary, to micro-manage from without the medical treatments that had traditionally been managed mainly by physicians and their patients. At the core of 'managed' or 'proctored' care lies the idea that practicing physicians need to be continuously educated with the aid of practice guidelines that reflect not only state-of-the-art, evidence-based medicine, and that they also need to be constantly reminded of the opportunity costs that the use of health care by one patient can visit on other patients or on society at large.

Unfortunately, until the worldwide quest for evidence-based medicine has succeeded in shoring up applied medical theory with a robust scientific foundation, and until 'managed care' has firmly taken root, modern medical practice worldwide will remain suspect of both clinical and economic illegitimacy. It is a cloud of suspicion from which the medical profession and its allied workers in health care cannot any longer escape.

Third-party payment and the compensation of providers

Matters are not helped by the necessity somehow to infuse money into the patient-provider relationship. Paying doctors and hospitals fee-for-service kindles the suspicion that they may overtreat patients, regardless of who actually pays the money. On the other hand, putting

physicians at financial risk through prepaid capitation payments or fixed annual budgets triggers exactly the opposite incentive – the incentive to undertreat. The in-between, paying physicians a salary, is thought to invite a lack of productivity. It turns out that there does not exist an ideal method of payment that does not have at least some shortcoming (Reinhardt, 1987). Therein lies a second source of perennial malaise over health care.

Suspicious about the economic legitimacy of health care are amplified further by the intrusion of third-party payment into the relationship between patients and providers – an issue that is distinct from the mere infusion of money into medicine. It is one of the express purposes of third-party payment to shield patients from the necessity of having to conduct, at the time of their illness, the cool-headed benefit-cost calculus on which the production and distribution of normal commodities rests (although, as noted, patients probably could not perform that task competently even they wanted to). We can be sure that an individual who purchases a pair of *Gucci* loafers with his own money expects from that purchase benefits whose monetary equivalent is at least as large as the amount he paid for the loafers, and generally larger. Up to a certain volume of consumption, the same can be said about pints of ale. Because that crucial benefit-cost test is absent in the typical health-care transaction, there is the perennial suspicion that insured patients will be reckless and wasteful in their use of collectively financed health care,⁵ all the more so if they are egged on by providers who book that waste as income (as they do in health systems that rely on fee-for-service compensation). Although it is fashionable in these times to blame the ills of health care mainly on government, thoughtful observers know that the problem is third-party payment *per se*, whether it be it commercial – or government-financed insurance.

The burden of being one's brother's keeper

Finally, in recent years the suspicion triggered by clinical practice variations and by third-party payment has been joined by a growing

5. Just as perennial is the irony that wasteful behavior in health care is invariably attributed to persons other than the person voicing that suspicion. In its editorials, for example, *The Wall Street Journal* regularly decries the untoward incentives of first-dollar health-insurance coverage. Remarkably, for its own employees (its editors included) *The Wall Street Journal* procures one of the most comprehensive and generous health-insurance policies.

resentment over the income redistribution that is inherent in most modern health-insurance systems.

In Europe, in Canada and even in the more individualist United States, there had long been a social consensus that better-off and chronically healthy citizens should subsidize with their insurance premiums or their taxes the health care of poorer or chronically sicker fellow-citizens. That consensus had worked well as long as the distribution of income was relatively narrow and the incidence of serious illness was thought to be primarily a matter of chance. The consensus became strained when the income distribution started to spread (de Gooijer, 1997), as it has in the past decade throughout the industrialized world, notably in the United States (*The Economist*, Nov 5, 1994). The consensus has been strained further by the growing belief, nourished by a growing body of evidence, that the incidence of illness is not just a matter of chance, but that is strongly influenced also by freely chosen life styles. In the minds of many, ill health has become simply a product of 'consumer choice'. Jan Blanpain of Leuven University refers to it as 'the growing tyranny of the healthy over the sick'⁶.

In the United States, there now is growing resentment of the income redistribution typically triggered by health insurance. The resentment manifests itself in an open rebellion against taxes that would finance health insurance for the roughly 40 million or so uninsured Americans – 10 million children among them (Reinhardt, 1996a, 1997a). The resentment breaks into the open also in states that by law require the premiums for commercial insurance to be averaged over entire communities, thereby forcing chronically healthy individuals to subsidize chronically ill individuals. There is no longer a tabu in the United States on disparaging community rated health insurance premiums, precisely because these 'actuarially unfair' premium rates force healthy individuals to subsidize sick individuals. As Victor Fuchs remarked in his presidential address to the American Economics Association, the market place in the United States by now has so segmented the insured by risk class as to have destroyed many of the hidden subsidies whereby hitherto the healthy had supported the sick (Fuchs, 1997, p.920).

The bulk of Americans under age 65 receive their insurance at their place of work, as part of total compensation, but only if the employer

6. Verbal communication with the author.

chooses to offer that fringe benefit. In many states, these premiums charged employers by insurers are 'experience-rated' for the individual firm, which means that this year's premiums are based on last year's health spending for only that firm's small number of employees. Serious illness in the family of only one employee can trigger huge annual increases in the premiums quoted the firm. Because this practice can put solidarity among employees under severe strain, many small firms prefer not to offer their employees any health insurance in the first place.

But even in states that do require insurers to charge employers 'community-rated' premiums, these ostensibly community-rated premiums are segmented into many distinct demographic groups, for example, into single individuals, one parent with children, married couples without children, two parents with children, or even finer distinctions. Furthermore, within each family type, the insured are segmented once again by the age of the employee. A separate premium is charged for each age cohort in each type of family. It follows that the average premium charged a firm can have large variances about that average. For 1998, for example, the Blue Cross/Blue Shield of the National Capital Area quoted a small firm in Washington, D.C. an overall average premium increase of 7.8 per cent over premiums paid in 1997, but the premium for the category 'one parent with child' in a particular age group actually rose by over 25 per cent. (Employees typically pay a sizeable fraction of the premium for their own risk category.) All of these rates are community-rated over the large area of Washington, D.C. and Northern Virginia. In fact, however, even these community-rated premiums are so segmented by risk class as to shift the cost of illness more and more from healthy to sick individuals.

Resentment over the personal cost of social solidarity in health care is likely to be mild where people have been educated to view their own health and their own position in the nation's income distribution primarily as the product of luck. Because a good part of that education comes from life's experiences, the commitment to social solidarity is likely to vary across generations. For example, the generations that suffered through the vagaries of the Great Depression and through the perils of World War II probably are much more impressed by the role that chance plays in human fortune than are their more coddled descendants. Many of these descendants seem to view personal luck as deserved. Furthermore, many of them do regard ill health as the product mainly of a chosen life style. Although at the

purely conceptual proposals for a 'market approach' to the allocation of health care can be crafted as a search for genuine welfare enhancement (Pauly *et al.*, 1991 and Pauly, 1997a), in its practical application the approach can be interpreted also as a desire among today's moneyed and politically influential elite to adapt the distributive ethic for health care to the pure meritocracy in which that elite believes to live (Evans, 1997a and 1997b, Reinhardt, 1997a). In the United States that tendency is now widely manifest. One wonders how much longer it will remain dormant among Europe's moneyed elite (de Gooijer, 1997).

The quest for better accountability

Uncertainty over the clinical merits of alternative medical treatments, the suspicion arising out of third-party payment and the requirement to subsidize the health care of people whom one suspects of leading unhealthy life styles, all go into the cauldron that brews the perennial discontent over health care everywhere. That discontent is a standing invitation for would-be reformers of the health system. At their core, all of the reforms being proposed pursue at least one common objective, namely, greater accountability on the part of all actors in the health system for the resources they conscript.

From physicians and other providers better accountability is sought for three distinct facets of their activities:

- (1) the real resources (human labor and other inputs) that are burned up in attempts to help individuals maintain or improve their health;
- (2) the money transfers (prices) that the providers of health care directly or indirectly extract from the rest of society in return for the real resources they contribute to the health system;⁷

7. The distinction between the real and the financial resources absorbed by the health system may be thought obvious, were it not so regularly overlooked by the providers of health care, who instinctively equate reductions of financial resources with reductions of medical care. Financial resources are generalized claims on real goods and services produced worldwide. They are given to the providers of care as a reward for the real resources they contributed to patients. Curtailing of the financial rewards certainly would detract from the quality of life enjoyed by providers; but it need not detract from the quality of life enjoyed by patients. In this connection, see Table 3 on page 54.

- (3) the contribution that the real resources used by the health system make to the well being of individuals and of defined populations.

From patients, better accountability is sought for the claims they make on the health-care system. That quest touches on two distinct questions to wit:

- (1) Is desirable to make the individual assume greater responsibility for the resources that are used in maintaining or improving his or her own health?
- (2) If prevailing social ethics dictate that the answer to the first question be 'No', is it nevertheless possible and desirable to enlist the individual as society's agent in forcing greater accountability and responsibility on the providers of health care?

Elementary textbooks in economics teach that, in many areas of organized human activity, the legendary Invisible Hand of the free market automatically forces the sought after accountability on both consumers and producers. In the process the free market is thought to allocate scarce resources much more smoothly and 'efficiently' than the government's clumsy Invisible Foot.⁸ Unfortunately, most textbooks in introductory economics fail to warn students with sufficient emphasis of the ideological content of the word 'efficiency'. This omission is of little consequence in connection with ordinary commodities – like the legendary 'widget' of textbook fame – whose distribution among members of society by ability to pay is assumed to have wide social acceptance. That omission is of very serious consequence, however, in connection with the class of commodities upon which the public would like to impose a more egalitarian distribution. In fact, given the widely expressed preference for an egalitarian distribution of health care – even in the United States (Taylor and Reinhardt, 1991) – a careless unleashing of market forces on the health sector can lead to a highly inefficient allocation of resources.

In the vernacular, the term 'inefficiency' tends to denote 'waste', which in turn is thought to be a patently useless application of resources. Retrieval of irrelevant information through diagnostic

8. US Congressman Richard Arney (Republican of Texas) has coined this term for government regulation.

testing, the performance of a coronary bypass graft judged patently inappropriate by clinical experts, or the presence of long queues in the face of poorly used capacity may fall into that category. In the debate on health policy, however, use of the term 'efficiency' goes much beyond these trivial cases. Under its banner march not only attempts to root out the waste in health care that any sensible person would identify as such. Under its banner also stalks a Trojan horse whose inside riders would redistribute the fiscal burden of illness from the wealthy to the poor and from the healthy to the sick. While such an idea may be legitimately put in a free society, it always should be put candidly up front, for a fair and open debate. As Alan Williams (1997) admonishes us wisely in his 'Priority Setting in Public and Private Health Care: A Guide through the Ideological Jungle':

I observe that many supposed 'improvements' in 'efficiency' contain implications for priority setting in health care which seem to me to have a quite strong (though implicit) ideological component.... So, when appraising policy proposals for improving each respective [health] system, let us state clearly whether our judgements flow from a basically libertarian or egalitarian stance (Emphasis added; p. 64).

At the risk of treading on ground familiar to at least some readers, it may nevertheless be useful to offer a little primer on the seductive and mischievous word 'efficiency'. To quote Robert Evans (1997b) in this regard:

It is necessary to restate the obvious from time to time, lest we be led astray by illusions (whether or not dressed up in mathematical symbols) (p. 508).

III EFFICIENCY AND SOCIAL GOALS

'Efficiency' is not something absolute that we can easily recognize when we see it. It is a more subtle term, like 'honor' and 'beauty'. 'Beauty' is judged against subjective standards that vary over time and from place to place. Analogously, 'efficiency' can be judged only against a crisply defined objective that is rooted in subjective norms. Unbeknownst apparently to many, in abstraction from a clearly defined objective the term 'efficiency' is meaningless.

In years of teaching economics to undergraduates, I have found it useful to explain the concept of efficiency first with appeal to road travel, which is simple and well understood (Reinhardt, 1997b). Thus, if one wanted to motor from London to Liverpool and get there as fast as possible, then the fastest land route leading to Liverpool would be the most efficient relative to the specific goal of motoring to Liverpool by car as fast as possible. A more circuitous route might be more scenic and might be the most efficient relative to a goal that gives scenic beauty some weight; but because it would take longer, it would be less efficient relative to the specified goal of 'getting by car to Liverpool, as fast as possible'. Yet even that less efficient route would be judged a much more efficient route to Liverpool than would the route one would judge most efficient if to Glasgow one wished to go.

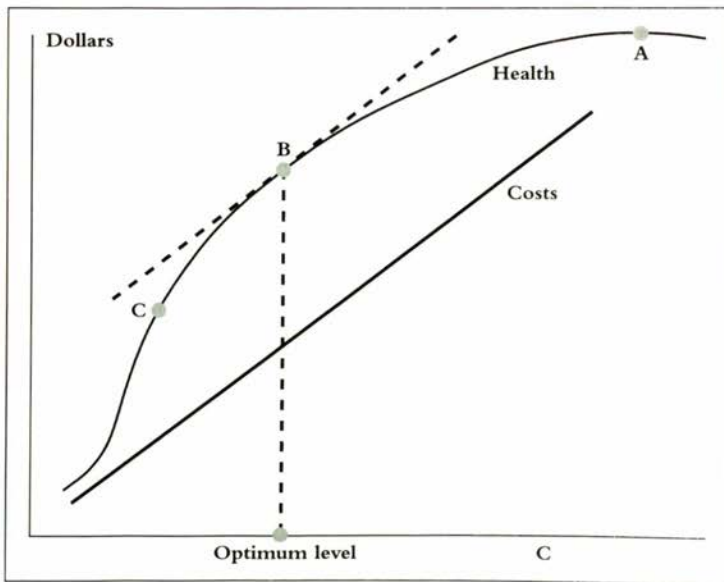
What is true of road travel is true of health policy as well. The relative efficiency of alternative health systems, or of alternative health-reform proposals, simply cannot be judged in abstraction from the specific goals that society posits for its health system. Prominent among the several dimensions of that goal is the distributive ethic that the system is to observe. Yet more and more one sees terms such as 'efficiency' and 'value' treated in the health-policy literature as something absolute, like jam, that transcends the varying objectives nations may posit for their health systems.

'Efficiency' and 'value' in health care

At the most abstract level, and leaving aside for the moment the tricky task of assigning monetary values to the outcomes yielded by health care, one might define an efficient health system as one that pushes the volume of health care rendered patients only to the point at which the incremental benefits reaped from the last unit of health care rendered just covers the incremental cost of producing that unit.

Figure 3, taken from a very early teaching paper by Victor Fuchs (1972), illustrates this general idea. That display is most intuitively appealing if one imagines that only one real resource goes into medical treatments and that the horizontal axis represents alternative medical treatments that might be given to a population with a given mix of medical conditions. The vertical axis in the diagram then represents the monetary value of the resources absorbed by the medical treatments (cost) and of the change in the quality of life that the alternative treatment regimens would bestow on the patients (benefits). The central idea and really the only illuminating idea that can be had with that display is that an efficient health system would not be found to operate at the top of the benefit curve (point A), at which further increases in the resource-intensity of treatments would be judged, by evidence-based medicine, as not efficacious. Rather, an efficient health system would stop at input level B and ration health care pervasively, but judiciously. It would ration health care in the sense that it would withhold efficacious treatments from patients. It would do so

Figure 3 **Determining the optimal level of health care utilization**



Source: Fuchs (1972), Figure 1, p.214.

judiciously, however, because it would increase the resource-intensity of medical treatments only as long as the incremental value thus produced can justify the incremental opportunity cost of the added resources burned up in the process. Although to vertical economists the wisdom of this prescription is self-evident (see Maynard, 1997), most physicians, most of their patients and possibly even some horizontal economists⁹ find it harder to accept.

The problem, of course, is how to descend from this high level of abstraction to more concrete, practical guidelines for 'efficiency' in health care. That descent into the real world is inherently political. While it may be uncontroversial to put monetary values on the opportunity cost of the resources burned up in medical treatments, it is impossible to hang monetary values on the outcomes yielded by those treatments without first positing explicitly a distributive ethic for health care. A decision must be made, for example, how to assign a value to a medical procedure applied to the child or an elderly person of a destitute family unable to pay for that care. To be sure, at the level of highly abstract theory, economists do know how to write down equations or diagrams that 'solve' this problem conceptually; but these academic exercises forever beg the question encountered at the practical level. At that level the valuation of health-care outcomes will always be inherently political and crude. Try as some economists might, they cannot run away from this conundrum.

One approach to the problem of valuing health care might be to have well-informed and enlightened health-sector planners assign monetary values to the typically multi-dimensional clinical outcomes from medical treatments. Perhaps such values can be extracted from the valuations that representative, middle-class citizens might place upon the various dimensions of the clinical outcomes from medical treatments. These valuations could be estimated either through carefully contrived experiments or from observed behavior in the market place. Researchers in the United Kingdom have been the pioneers in this effort (Williams, 1974; Drummond, 1981, Drummond *et al.*, 1997; Culyer, 1991; Ryan, 1996). In terms of Figure 3 above one could think of such efforts as attempts to identify an optimal global health-care budget that would then be imposed upon the entire nation or on health districts within it.

9. A vertical economist is in good health. A horizontal economist is one who has fallen seriously ill.

Critics of health-sector planning – American economists prominently among them (Enthoven and Singer, 1994; Pauly, 1994) – rightly worry that the planners might not get it right, that they would either over- or underfund the health system relative to the preferences of the citizenry. There is something to this criticism. In the midst of a wide distribution of individual preferences, even the most carefully determined single global budget for a nation is apt to leave millions of citizens unhappy with the resulting level of health care provision. Many citizens will think too much is being spent on health care and many others will deem it too little. Perennial disagreements with prevailing policy on either side of the imposed global budget are guaranteed, even if the planners do not err and do not allow political pressure to cloud their judgments (Hoffmeyer and McCarthy, 1994; Healthcare 2000, 1995; Dixon, Harrison and New, 1997).

This perennial shortcoming of health sector planning has given birth to the comforting idea that ‘the market’ would neatly circumvent all of the difficulties engendered by the ‘murky area of ‘societal decision-making’ of planners (Pauly, 1994, p. 371). Private markets do, after all, cater splendidly to differences in individuals’ preferences (Pauly *et al*, 1991). At its best, the idea would be to endow each individual in society with sufficient purchasing power to afford him or her the health care judged to be minimally adequate by the rest of society. Properly informed individual recipients of health care could then assign benefits and costs to the alternative medical treatments they might be offered when they are ill. In the process individuals would determine the treatment intensity that is most ‘efficient’ for them, given their own tastes and their endowment with purchasing power. On the tacit assumption that the market for health care more or less does meet the rigorous conditions of perfectly competitive markets, virtually every point on the benefit curve in Figure 3 could then be assumed to be ‘efficient’ for someone in society. No recourse would need to be had to something as ill-defined and perennially controversial as ‘societal values’ to determine an ‘efficient’ health care budget for the nation. Therein lies the seductive charm of the market approach to health policy.

One certainly can question the faith underlying this approach on the ground that the essential conditions for a competitive markets usually are not met in the bulk of health-care transactions (Rice, 1997). More troublesome, however, is tendency among so many market devotees to be cavalier about the actual income distribution

onto which their policy prescriptions would be grafted (Friedman, 1991; Epstein, 1997). What if it were known with reasonable certainty that the political process would never actually generate the prior redistribution of generalized purchasing power that is posited by the more conscientious among the market devotees, but that for some reason the political process would countenance a relatively equitable distribution of benefits in kind (here health services)?¹⁰ Can it be blithely assumed that, in a democratic society, the prevailing income distribution already properly reflects the distributive ethic that the general public would like to see imposed on health care, or else the political process would automatically trigger a redistribution of income (Pauly, 1996; p. 253)?

‘Efficiency’ and ‘value’ in the ‘market’

To illustrate the importance of this point, consider how the celebrated American Nobel Laureate economist Milton Friedman uses the term ‘efficiency’ as he ventures into health policy. Writing in *The Wall Street Journal* (November 12, 1991), Friedman professed to be inspired by the study of the British physician Max Gammon who, according to Friedman,

took the number of employees [in the British socialized hospital system] as his measure of input and the number of hospital beds as his output. He found that input [so defined] had increased sharply, while output [so defined] had actually fallen. In his [Gammon’s] words, ‘in a bureaucratic system... *increase in expenditure will be matched by a fall in production* (Italics in Friedman’s editorial).

Applying that methodology to the United States, Friedman concluded that ‘Gammons Law has been in full operation for US hospitals since the end of World War II, and especially since the enactment of Medicare [the federal health-insurance program for the elderly] and Medicaid [the federal-state health-insurance program for the poor] in 1965’. This conclusion then led him to the following bold policy pronouncement:

10. For an elaboration on the economist’s peculiar and probably misguided obsession with the distributions of benefits in kind, see Reinhardt, 1997b; pp.37-39).

The inefficiency, high cost and inequitable character of our medical system can be fundamentally remedied in only one way: by moving in the other direction, toward re-privatizing medical care... The [proposed] reform has two major steps: (1) End both Medicare and Medicaid and replace them with a requirement that every US family unit have a major medical insurance policy with a high deductible, say \$20,000 a year or 30 per cent of the unit's income during the prior two years, whichever is lower (Emphasis added).

To put Friedman's policy recommendation in perspective, it may be noted that in 1990, at about the time Friedman formulated his recommendation, median pretax income in the United States was \$29,943 for all households and \$35,353 for 'families', that is, for households with two or more member (Stockman, 1996, Table 18.2, p.500). If we generously assume that Friedman meant to base the recommended deductible not on the sum of the family's income during the past two years but only the average annual family income over the prior two years, then that deductible in 1990 would have been \$10,500 per year for a family with median pretax income of \$35,353. The outlays on health care of a relatively healthy family probably would not have reached that deductible. A family stricken with serious, chronic illness almost surely would have had to pay that much out of pocket before insurance coverage would set in. In addition, of course, each family would have to pay the premium for the catastrophic insurance policy.¹¹

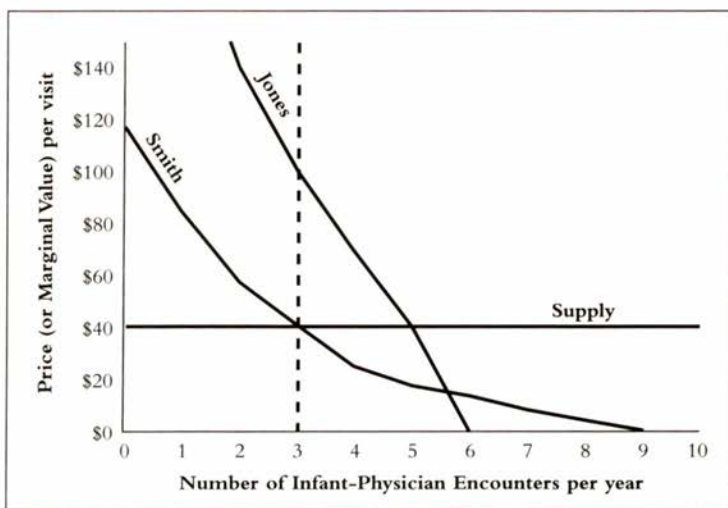
Friedman injected his editorial into the presidential election campaign of 1991-92, in which health policy had moved to center stage. He wrote not purely for his colleagues, in a scientific journal; he wrote in a prestigious medium read by most private and public policy makers in the United States. He acknowledged the contribution to his editorial by fellow Nobel Laureate economist Gary S. Becker of the University of Chicago and by economist Thomas Moore, PhD, formerly of President Reagan's Council of Economics Advisors and now at the Hoover Institution of Stanford University. We may therefore regard the editorial as a significant statement made by prominent American economists who sought to influence with their normative analysis both the election and the path

11. Friedman would, however, let government subsidize low-income families who could not afford to purchase the catastrophic insurance policy in the private market.

of public health policy. Friedman's prescription is a close cousin to the concept of the Medical Savings Account (MSA) that is now highly popular among many American politicians. At the core of that concept is a catastrophic insurance policy, with an annual deductible of, say, \$3,000 to \$5,000 per family, that is coupled with a dedicated, individual savings accounts into which the family may make annual tax-deductible contributions up to a certain amount (but not more than the deductible). Under the progressive income tax of the United States, the MSA has the effect of making the after-tax cost of given medical services cheaper for high-income families in high tax brackets than it is for low-income families in lower tax brackets.¹²

Figure 4 makes graphic how Friedman (and like-minded market devotees, e.g., Epstein, 1997) would hang monetary values onto the benefit curve in our earlier illustrations. Shown in Figure 4 are two families' hypothetical marginal-value curves for ambulatory visits of their baby to the office practice of a pediatrician.¹³ A consumer's

Figure 4 'Marginal-value' or 'willingness-to-pay' curves for pediatric visits (alias 'demand curves')



12. Friedman, however, does not favor the tax-deductibility of health insurance premiums of deposits into MSAs.

13. The graph is taken from a homework assignment in first-year economics that was subsequently published in Reinhardt (1997b).

marginal-value curve for a particular commodity indicates the maximum amount of money the consumers would be willing to pay for privilege of consuming the n^{th} unit of the commodity per period, given that he or she already consumes $n-1$ units per period. The curves are assumed to slope downwards on the hypothesis that consumption of successive units of the commodity per period will bestow successively lower additional happiness ('utility') on the consumer. Readers who have suffered through elementary courses in economics will remember these curves also by the name 'willingness-to-pay curves' or simply 'demand curves'.

In Figure 4, the Jones family is assumed to be wealthy and its baby healthy. The Smith family is assumed to be poor and its baby sickly. If at identical incomes and health status the two families would have identical marginal-value curves for pediatric visits, then it is plausible to suppose that the actual differences their health status and family income might beget the marginal-value curves shown in Figure 4. Suppose now that the two families lived in Friedman's ideal world, with its enormous deductibles, and that office visits could be procured by the two families at an out-of-pocket price of \$40 per visit, which we assume to reflect the social opportunity cost of producing these visits. Then, according to Friedman and like-minded market devotees, an efficient allocation of health care would bestow 5 visits per year on the healthy Jones baby, but only 3 visits on the sickly Smith baby. Physicians and public-health planners may be stunned that anyone would call such an allocation efficient. But reversing the allocation – granting more visits to the sick child and fewer to the healthy child – would be 'inefficient', as that term is defined in standard 'welfare economics'.¹⁴

14. First-year students in economics learn from their textbooks simple propositions such as the following: 'According to the efficiency criterion, any change in policy that makes George \$2 richer and Martha only \$1 poorer is a good thing... More generally, the efficiency criterion pronounces that between two policies, we should always prefer the one that yields the higher social gain' (Landsburg, 1995; p.247). Following that dictum, if health planners initially had allocated 5 pediatric visits per year to sickly Baby Smith and only 3 visits to healthy Baby Jones, then a 'social gain' of \$50 could be achieved if we took away one visit from sickly Baby Smith and gave it to healthy Baby Jones. This is so because the low-income Smith family valued the fifth visit that sickly Baby Smith would lose at only about \$20, while the wealthy Jones family values the fourth visit that healthy Baby Jones would gain at about \$70. Ergo, says standard welfare economics, there is a 'welfare enhancement' of \$50.

Furthermore, according to Friedman the policy-relevant 'social marginal value' of, say, the third pediatric visit per year would be \$100 if it were bestowed on healthy Baby Jones, but only \$40 if it were bestowed on sickly Baby Smith. Although that proposition, too, may stun persons not familiar with the doctrine of standard welfare economics, according to that doctrine the social value of a commodity depends as much or more on the wealth of its recipient as it does on his or her craving for the thing. When Friedman and like-minded market devotees speak of the ability of free markets to maximize the 'value' to be had from a given resource base, it is this method of valuation that they have in mind. Persons who have trouble with applying that valuation principle to health care will have trouble also with the concept of 'efficiency' that is espoused by Nobel Laureate Friedman and by his many disciples all over the world.¹⁵ A point always to remember, then, is that it pays to be skeptical whenever economists speak of 'value' and 'efficiency'.

It is useful to explicate the ethical implications of the free-market approach in their full detail, because that approach is so often marketed not with the blunt candor that so controversial a doctrine warrants, but instead with the highly seductive language and imagery of economics. Who could possibly be against 'consumer sovereignty', 'consumer choice', 'consumer empowerment', 'individual responsibility', 'economic efficiency', 'enhanced economic welfare' and similarly felicitous terms into which the approach is so often wrapped? Behind these felicitous words, however, there lurks a quite distinct distributive ethic. To emphasize again, that ethic may be legitimately espoused in a free society; it is neither right nor wrong. It should, however, be made explicit, up front, by any analyst who would offer a 'market approach' as the panacea for our perennial health-care malaise.

Surely neither Professor Friedman nor anyone else subscribing to his policies (for example, Epstein, 1997) would assume for a moment that under his proposal (which includes the abolition of the popular Medicare and Medicaid programs) the distribution of health care in

15. For a truly enlightening exchange of views on the strength and limits of modern 'welfare economics' see Pauly (1994) and the comment thereon by Culyer and Evans (1996); also Evans (1997a), Rice (1997), Pauly (1997a), Evans (1997b).

the United States, the distribution of the financial burden of illness, and the socio-demographic profile of health status would be the same under his proposal as they would be in the presence of these programs. In terms of the imagery of road travel employed earlier, Friedman's proposal might get us to the health-care analogue of Glasgow (the rationing of health care and life-years mainly by price and the individual's ability to pay) when, for all we know, the majority of Americans might well prefer the health care analogue of Liverpool (access to health care by all members of society, on roughly equal terms, regardless of the individual's ability to pay for his or her own health care). After all, none other than Republican President George Bush had flatly declared, in his State of the Union address in 1991, that 'good health care is every American's right', a sentiment widely shared also among the American public (Taylor and Reinhardt, 1991), if not by the nation's current policy-making elite.

Quasi-market approaches: 'regulated' or 'managed' competition

Not all health policies marching under the banner of 'the market', of course, go as far as that advocated by Friedman and like-minded disciples, nor do all of them abstract from the distributive impact of the policy being proposed. Some proposals leaning towards a market approach are explicitly premised on a prior, progressive redistribution of purchasing power, by means of vouchers sufficient for a minimally adequate health insurance policy (see, for example, Pauly *et al.* 1991, Butler, 1991 or Reinhardt, 1993). Unfortunately, in the debate on health policy the term 'market' has become so wide an umbrella as to rob the term of distinction. In between completely government-run health insurance and health-care delivery, on the one hand, and the bold privatization envisaged by some American economists, on the other, lies an entire spectrum of arrangements that seek to hold the providers of health care more accountable for their decisions than hitherto they have been.

Some of these proposals seek to enlist patients more directly in that task, without rationing essential health care by price and the individual's ability to pay. Some versions of what is now known as 'managed competition' fall into that category. Unfortunately, the term 'managed competition', too, has become so broad a term as to accommodate an entire spectrum of distinct distributive ethics. Worse

still, in the popular American press and abroad, the term is often confused with term ‘managed care’, although the two are not at all the same. ‘Managed care’ involves the proctoring and, sometimes, regulation of doctors and other health-care providers who help individuals manage their health. ‘Managed competition’, on the other hand, involves the regulation and sustained proctoring of rival health-insurance plans as they compete for subscribers. Naturally, if the rival health plans derive their revenue in the form of competitively bid or publicly regulated prepaid capitation payments for comprehensive health care, then the economic pressure unleashed by ‘managed competition’ on the health plans usually does force them to adopt stringent ‘managed-care’ techniques as a tool of cost-control and risk management. ‘Managed competition’ then goes hand in hand with ‘managed care’. In principle, however, neither concept necessarily implies the other.

Furthermore, ‘managed care’ *per se* has relatively little to do with the distributive ethic imposed on health care.¹⁶ For the most part, that ethic is a facet of the structure of ‘managed competition’. Ideally, that structure should be a derivative of an explicit social ethic – such as the principle of solidarity – and not the other way around. Unfortunately, in the United States the distributive ethic for health care has become more and more the inadvertent by-product of a commercial free-for-all. In this respect the European nations still have the opportunity to put the horse before the cart. Should they espouse the idea of managed competition at all, as well they might, they can tailor their version of it firmly to the ethical framework that the public actually prefers.

16. It might do so only if, for example, a rival health plans were evaluated and financially rewarded on the basis of population-based average health statistics, which might influence the allocation of real health-care resources among enrollees in a plan, albeit in ways that health planners probably would find both efficient and equitable.

IV 'MANAGED CARE': THEORY AND PRACTICE

The ultimate objective of 'managed care' is to encourage greater accountability on the part of the providers of health care for the resources they devote to the delivery of health care. It was noted in Section II that this accountability touches on three distinct facets, repeated here for the reader's convenience:

- (1) the real resources (human labor and other inputs) that are burned up in attempts to help individuals maintain or improve their health;
- (2) the money transfers (prices) that the providers of health care directly or indirectly extract from the rest of society in return for the real resources they contribute to the health system;
- (3) the contribution that the real resources used by the health system make to the well being of individuals and of defined populations.

In the United States, none of the three facets of managed care had been managed at all until about the mid 1980s. Furthermore, they were managed first in the public insurance programs for the poor (Medicaid) and the elderly (Medicare). In the private sector, attempts to control either fees or volume did not effectively start until the late 1980s and early 1990s. In fact, the sheer novelty of any attempt to control either the prices or the volume of health services, and the suddenness with which the idea spread, may explain the extraordinary excitement that the concept of 'managed care' has triggered within the United States and why Americans consider 'managed care' their very own invention. It is not.

'Managed care' outside the United States

In respect of the first facet of managed care, the control of the real resource flow, none of the other industrialized countries has allowed the volume of services rendered to patients to be dictated solely by the providers of health care, as has been the practice in the United States until the early 1990s as well. Instead, under the fee-for-service systems of Canada and of continental Europe, individual physicians have been constrained in various ways in their conscription of real health-care resources. Sometimes these constraints have taken the form of limits on physical capacity. In other instances they have been based on detailed physician practice-profiles of individual providers (notably physicians) who are reined in when their profiles deviate noticeably

from the mean or some other standard. Such practice profiles are only now coming into use in the United States.

Most other industrialized nations have for years controlled fairly well the second facet of managed care, the flow of the money-transfers into their health systems. None of these countries would ever have thought to leave fees and total health care budgets mainly to the discretion of health care providers, as had been the practice in the United States until the late 1980s (see below). Instead, these countries have long formally negotiated these money-transfers with the providers of health care, and America could have learned from them how it is done. Reductions in the money transfers into health care need not detract from the quality of health care and may even enhance it. For example, in a comparative study of the treatments given to patients with systemic lupus erythematosus (SLE), for example, the authors (Gironimi *et al.*, 1996) found that despite significantly greater per-patient expenditures in the United States (\$10,530 in the U.S. vs. \$5,271 in Canada), Canadian patients received at least as many health services (hospital stays, hospital days, medications and emergency-room visits) as did their American counterparts. The conclusion that patients in other countries receive more real health services than do American patients, albeit at lower money transfers to health-care providers, is also reached in several other studies (e.g. Fuchs and Hahn, 1990; Pauly, 1995; Welch *et al.*, 1996, McKinsey & Company, Inc., 1996).

Many other techniques of 'managed care' rediscovered by Americans have long been practiced elsewhere as well. For example, short maternity stays coupled with a visiting-nurse program were used in the United Kingdom long before the American managed-care industry stumbled upon the idea (Lyal, 1995). Under the rubric 'HMO Innovations' one reads that the managed-care industry in the United States has only recently 'discovered' that physicians had best specialize either in ambulatory care or in hospital-based practice and that 'the future in health care is likely to include full-time hospital-based internists' (Lindblad, 1996; p.124). Wachter and Goodman (1996), who are at the forefront of this approach in the United States, have christened these hospital-based physicians 'hospitalists'. The authors are cosmopolitan enough to know that hospitalists 'have long had a central role in urban hospitals in Canada and Great Britain', although even they seem unaware that the idea has long been in vogue also in continental Europe and in many other parts of the world. Finally, in a recent issue of *DOK*, the monthly publication of

Germany's local sickness fund association, one reads that physicians and their patients have direct access on the Internet to over 300 (soon to be 1,000) clinical practice guidelines for a variety of illnesses (Oldiges, 1997). Here, too, the United States possibly could pick up pointers from the experience abroad.

In short, if Americans were as eager to learn from abroad as foreigners are eager to learn from Americans, then many techniques of 'managed care' hailed by Americans as their own inventions would be more properly regarded as an American rediscoveries. Indeed, the relatively low levels of health spending in most other industrialized nations and their relatively superior health-status indicators should have made Americans suspect all along that these systems may offer many useful insights on managing health care more effectively than it is done in the United States. After a lengthy study tour of Europe, Donald Berwick (1996), an internationally recognized American expert on quality control in health care, chides his isolationist American colleagues on their penchant for reinventing the wheel in health care. Because of his stature in the field, he merits extended quotation on this point:

I visited Haukland Hospital in Bergen, Norway. It is a first-rate, academic, high-tech referral center where the equipment, access, ambiance, and service levels seem at least as good as in any comparable American facility familiar to me. What is unfamiliar is its costs. Although the exact figures are elusive, the Haukland Hospital seems to be operating for 25-40 per cent lower cost per unit of service than a U.S. facility would... So why are teams of American managers and clinicians not crawling all over Haukland Hospital to seek clues to solve their local problem of cost and quality?... Caesarean section rates in several European countries are one-third those in the US, or even less, with better maternal and fetal outcomes. One might predict a stampede of [American] clinicians and managers to these 'benchmark' systems, curious to study, learn and copy better ways, but we see at best a trickle of inquiry... We [Americans] stand to harvest lessons of immense value from the serious study of organizations and systems far from our own.... When our awareness of our differences impedes our learning [from other nations], we pay a high price in missed opportunity (p.2).

Several cross-national studies support Berwick's contention. In their comparative study of spending on hospital care in Canada and the

United States, Newhouse, Angerson and Roos (1988) found that Canada spent about 50 per cent less per capita on hospital care than did the United States, leaving the authors to wonder 'what, if anything, the United States bought for that additional expenditure' (p.12). In a subsequent comparative study on the use of cardiac procedures and outcomes in elderly patients with myocardial infarction (Tu *et al.*, 1997) the authors found that American patients received far more resource-intensive treatments than Canadian patients. But while the 30-day mortality rate was slightly lower in the United States than it was in Canada (21.4 per cent vs. 22.3 per cent), the one-year mortality rates were identical. *Business Week* recently reported on the so-called *Eurofetus* study according to which the United States has only about half European rates for testing patients at risk with ultrasound procedures (Freundlich, 1997). Even more disturbing was the finding that the procedure, as it is currently applied, 'is three times as accurate in Europe as in the US – at a quarter of the cost'. Apparently, according to the study, the difference in accuracy reflects differences in the locus of the procedure. In Europe, the procedure is done mainly in hospitals, by specially trained and certified technicians. By contrast, in the United States 'any doctor can buy ultrasound equipment and begin scanning without special training' (p.85).

Long accustomed to the axiom (not merely the hypothesis) theirs is 'the best health system in the world', Americans naturally tend to be rather more generous in the giving of advice on managing health care than they are eager to receive such advice. American patients, if not American providers of health care, may be paying a high price for that pride.

An area in which the United States probably will lead the rest of the world is the third facet of 'managed care', that is, holding the providers of health care formally and systematically accountable for the health outcomes they achieve with the real resources entrusted to them. This facet has been as sorely neglected in Canada and in Europe as it hitherto has been in the United States. At this time, however, a massive research effort on the problem is being funded by both the public and the private sectors in the United States, and preliminary outcomes data on individual physicians and hospitals are published in the daily media with a brazenness that would shock Europeans. 'Managed care' aficionados abroad would do well to concentrate their search quite narrowly for useful insights mainly on that facet of the American health system.

'Managed care' in the United States

To appreciate just how novel the experience of 'managed care' is to the American health system, and why it evokes so much excitement in the United States at this time, it is worth describing to a foreign readership just how uncontrolled the American health system had been until very recently.

Until the mid 1980s, American business firms, and government as well, had literally surrendered to the providers of health care the keys to their sundry treasuries. Health care was managed strictly by physicians and their patients, while third parties paid more or less passively whatever they were charged by the providers of health care. Until the mid 1980s, for example, the Medicare program for the elderly reimbursed each individual hospital retrospectively for the costs it reported to have incurred on behalf of elderly patients insured by that program. Private payers paid hospitals their 'charges', set by each hospital literally at its own will. As a result, there arose enormous, indefensible inter-hospital differences in payments for identical services. Because price did not seem to matter in the competition for patients, hospitals sought to compete instead with sophisticated technology, a practice known as the 'medical arms race'. Widespread excess capacity in staffed beds and in expensive technology thus became a permanent feature of the American health system.

Remarkably, the first stirring of cost control in the United States came not from the private-insurance sector (which accounts for about 33 per cent of all health spending in the United States and now claims primacy in cost control), but from the public sector (which accounts to about 44 per cent of total national health spending).¹⁷ Only in the early 1990s did private health-insurance bestir itself to control its outlays on health care.

As early as the 1970s the state-run Medicaid programs for the poor had imposed price controls on doctors and hospitals, albeit no volume controls at all. Since the mid-1980s, the federal Medicare program for the elderly began to impose on hospitals administered prices. Under that system, each hospital is paid a flat fee per inpatient case, with cases categorized into some 500 distinct diagnostically-related groupings (the DRGs). In principle, these per-case payments are to be uniform

17. The remainder is paid by patients, out of pocket and at the time services are received.

across the United States, although there are still many adjustments made for local market conditions and for capital expenditures. There are no controls, however, on the number of inpatient cases that can be billed to Medicare.

Until 1992, the fees Medicare paid doctors were based on the individual physician's 'customary, usual and reasonable' fees. Although some limits eventually were imposed upon what was deemed 'reasonable', this unwieldy system begot enormous inter-physician differences in fees for the same procedure, not only across regions, but within the same medical-arts building in a given city. In fact, until 1992 there were not even uniform codes of procedures on which physician payments by Medicare were based. Canadians and Europeans must find it incredible in the true sense of the word that only since 1992 has Medicare started to shift gradually towards paying physicians on the basis of a uniform national fee schedule, a process that has yet to be completed.

While cost control was largely absent from the public health insurance programs until the mid 1980s, it had been totally absent in the private insurance sector until about 1990. Until then, there were no controls at all on the volume of physician or hospital services rendered privately insured patients. Nor were there significant controls on prices. Private American insurance carriers basically paid individual doctors and hospitals their 'usual and customary' charges which, practically, has meant 'whatever the doctor or hospital charged'. Only egregiously high charges might have been disallowed and clipped. Once again, Canadians and Europeans will find it truly incredible that the private insurance industry has never been able to evolve a shared, nationally uniform fee schedule for physician – not even a common relative value scale or a common nomenclature – on which fees could be based. There has never been a uniform fee schedule for hospitals in the private insurance sector either. Until the advent of managed care in the 1990s, every hospital could charge private carriers literally at will, with lengthy bills running into dozens of pages per hospital stay, specified to the detail of a single pill, blood count or band aid, but without any control whatsoever on the prices put on the pill, the blood count or the band aid.¹⁸ The private insurance industry was simply too splintered to be able to offer

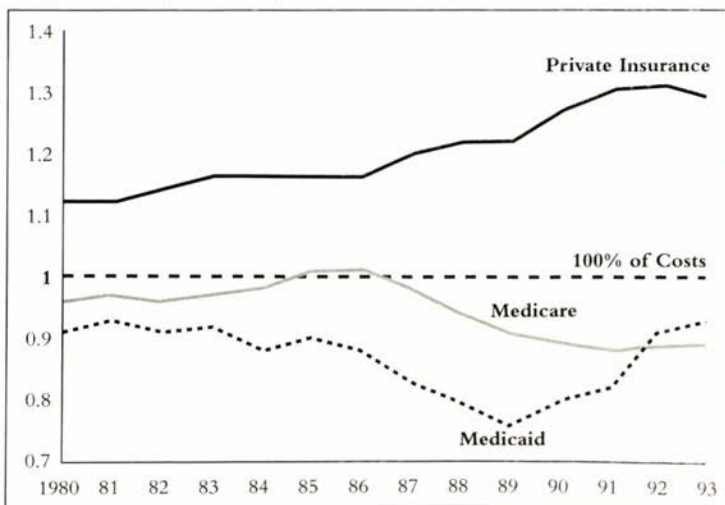
18. There arose in the popular press the jesting about the \$5 aspirin.

providers any countervailing market power at all on fees.

Many managed-care plans have now replaced these charges with per-diem charges that are negotiated annually between each hospital and each health plan. Consequently, a hospital now may have separate payment arrangements with several dozen health plans and continue to bill 'charges' with varying ad-hoc discounts to patients not enrolled in a managed-care plan. It is an arrangement that borders on perfect price discrimination, that is, the charging of different prices for the same item, depending upon the customer's ability to resist high prices. The hospital's administrative expense of operating this complex billing system are enormous (see Table 3 on page 54).

In short, it is fair to assert that, until the early 1990s, health spending under the private insurance system in the United States was driven totally by the supply side of the market. In fact, as is illustrated in Figures 5 and 6 below, the inflationary spiral triggered by the private health-insurance sector actually pulled along the public sector, whose prices limped forever behind the ever escalating prices passively paid by private insurers. Not surprisingly, toward the late 1980s the health-insurance premiums that private insurers charged employers for their

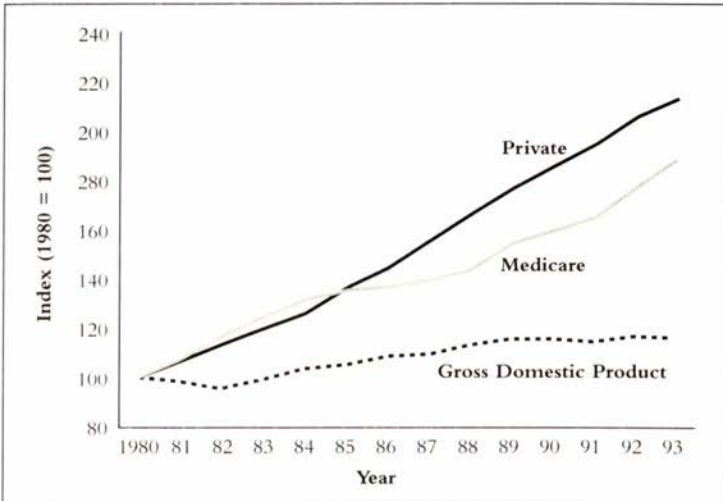
Figure 5 The inflationary pull of private health insurance on hospital compensation, United States, 1980-93



Source: Prospective Payment Assessment Commission (1995; Table 1-8).

Figure 6 Trends in health spending per capita, United States, 1980-93

The Federal Medicare Program vs. The Private Health Insurance



Source: Physician Payment Review Commission (1996), Figure 1-2, p.4.

employees' insurance coverage grew at annual compound rates anywhere between 10 per cent to 20 per cent. Nor is it surprising that attempts to confront at long last the seemingly uncontrollable growth in health spending started in the sector whose reckless behavior had let American health spending spin out of control in the first place: the private sector.

Attempts by private employers to rein in their outlays on health care were greatly facilitated by a recession in the late 1980s and by widespread corporate downsizing. Both had served to heighten insecurity among employed Americans. More concerned about a job than the details of their insurance coverage, employees were willing to forego the traditional, open-ended health insurance they had hitherto expected from their employers. They accepted instead the more limited choice among doctors and hospitals that is typical of classical, closed-panel health maintenance organizations (HMOs). Once the principle of limited choice was accepted by employees, private insurers hastily established new HMOs that contracted selectively with only subsets of doctors and hospitals. Selective contracting, in turn, gave the

insurance industry new-found economic leverage over individual doctors and hospitals. For the first time in thirty years, the fees charged private insurers by doctors and hospitals were actually negotiated in earnest. For hospitals the negotiated prices typically were flat per diems. For physicians, fees came to be based on the relative-value scale that had been developed earlier by the public Medicare program.

On the basis of their new-found economic leverage, private insurers also were able to subject physicians to various forms of utilization controls – either through ex-post physician profiles (of the sort that had been used in Canada and continental Europe for decades), or through concurrent review of medical treatments, or through required pre-authorization of expensive procedures, on the basis of hastily constructed and highly controversial medical practice guidelines.

This program of private-sector cost control has borne significant fruits since about 1992. Total national health spending, which had tended to grow about 3 percentage points faster than the rest of the GDP during the entire period 1960-1990, grew at only about the same rate as did GDP during 1993-96. During that period, health spending stabilized at about 14 per cent of the GDP which is, however, still about twice the comparable ratio in the UK and far above the 8 to 10 per cent spent elsewhere in the industrialized world (see the earlier Figure 1). On average, the annual growth of health-insurance premiums paid by employers in the private sector plummeted from the high double digits of the late 1980s to the low single digits – in some recent years even below the general inflation rate. For the first time in about a decade, that growth rate actually fell below the growth in per-capita health spending under the public Medicare program. The switch was widely taken as a sign that the private sector had found the magic bullet for cost control and that the public sector needed to follow suit.

Alas, in recent months the media report renewed upward pressure on health-insurance premiums in the private sector. A booming economy has driven unemployment to historically low levels, which has emboldened employees in the private sector to demand a wider choice of doctors and hospitals in their employer-paid health-insurance plans. The managed-care industry has complied by ever widening the network of providers included in its various insurance products. 'The market is telling us that [closed-panel] HMOs are on the decline', declared an industry executive in a recent interview with *The New York Times* (Freudenheim, 1997, p.A1). According to the report, fussy Baby Boomers increasingly are gravitating towards arrangements 'almost as

flexible as the old fashioned fee-for-service system' (p.D2). The price of that wider choice appears to have been a loss of economic leverage on the part of the health-insurance plans, who report increasing difficulty in their attempts to control their outlays on health care, whose profits have plummeted and the market price of whose stock has fallen sharply on Wall Street.¹⁹ Most of these plans now seek to revive their market value not by controlling their outlays on health care, but simply by raising premiums. The Minnesota state government, for example, and many small employers in the state 'will all be swallowing 12 percent increases in HMO premiums next year' (Freudenheim, 1997; p.D2). Similarly, the Federal Employee Health Benefit (FEHB) program, which has always been held up as a model of 'managed competition'²⁰ and which is widely viewed as a bell weather for the insurance industry as a whole, now faces an overall average premium increase of 8.7 per cent for the coming year (1998), with considerable variance about that average. Such an increase exceeds once again the comparable increase in per-capita spending under the public Medicare program, raising doubts about the ability of the managed-care industry to help control spending under these public programs.

At the time of this writing (the fall of 1997), it is anybody's guess whether the managed-care revolution in the United States will go next. There seems agreement among analysts that the industry's spectacular early successes in reining in the growth of health spending has consisted essentially of picking low-hanging fruit – mainly in extracting price discounts from high-priced physicians and hospitals who had hitherto been able to set their fees at will. To be sure, there have been some remarkable, isolated, local successes in curbing the real resource flow in health care through utilization controls. For the most part, however, that effort has consisted of the now much decried

19. The stock of Connecticut-New York based Oxford Health Plan, inc. fell by 75 per cent in after October 1997. The stock of California based PacifiCare Health Systems, Inc. tumbled by 21 per cent in November. Because their computer systems were not up to the task of managing even the cash flow through their businesses, both HMOs discovered rather late that their actual outlays on health care had far exceeded budgeted expectations.

20. Under that program, federal employees receive a voucher for a fixed dollar amount with which they can shop among a multitude of competing insurance programs, paying any difference between voucher and the insurance premium out of their own pocket.

practice of refusing referrals to specialists, and the equally controversial and probably ill-advised quest to reduce the average length of hospital stays (ALOS) by substituting care at alternative sites for hospital care.

The increasingly popular idea that overall national health spending can be reduced by emptying the hospital may turn out one of the major fallacies of managed care (Reinhardt, 1996b). It seems to rest on a confusion between the total costs (including overhead allocations) and the truly avoidable, incremental costs of a patient-day in the hospital. In the obsessive quest to reduce the ALOS in hospitals, patients may be moved from the hospital setting with low incremental costs into alternative sites (free-standing nursing homes or home care) with much higher incremental costs. These transfers make seeming economic sense to the health plans, because they think in terms of the flat per diems that they pay hospitals, regardless of the day in a hospital episode. The per-diems naturally are based on average costs. Many transfers to alternative sites often would not make sense at all if they were evaluated on the basis of truly incremental costs. This is especially true for the latest vogue in American health care, the transfer of severely ill patients into home care, replete with expensive home infusion and parenteral feeding. Unfortunately, judiciously applied micro-economics has not been the managed-care industry's strong suit.

Other students of health care have come to the same conclusion concerning the trade-off between hospital care and care at alternate sites. In his review of European health systems, Berwick (1996) observes that

it intrigues me that national per capita health care costs correlate poorly with average length of stay; it leads one to wonder whether we should be putting so many American cost-control eggs in that basket (p.2).

In their *Dartmouth Atlas of Health Care*, Wennberg and Cooper (1998) conclude that

there was no evidence of trade-offs between other alternatives to acute hospital care and inpatient care... Greater levels of expenditure for outpatient services were not associated with lower levels of expenditure for inpatients services (pp.72-73).

But what of the third facet of managed care, accountability for the contribution that the use of real resources by health care providers actually makes to their patients' quality of life and to the general health status of the entire population (that is, to what is loosely called 'outcomes')? As noted earlier, a massive research effort is underway in

the United States to tackle this difficult problem. The sheer size of that effort and its generous funding may eventually make the United States the leader on this facet of managed care, although similar efforts are underway in other countries as well. At the practical level, however, there has not been any more noticeable concrete progress on this facet in the United States than there has been elsewhere in the world. Systematic accountability for the outcomes achieved with the real resources used in health care remains the tale of futurists.

V 'MANAGED COMPETITION': THEORY AND PRACTICE

'Managed competition' is the provision of an orderly market in which different health-insurance plans, and the network of health-care providers they represent, compete fairly and honestly for enrollees. It is the health-care analogue of a farmers market in which farmers offer their wares in open and honorable competition. Crucial dimensions of a system of managed-competition are (1) the basis on which competition takes place and (2) the information infrastructure supporting the system and (3) a private or public authority that is empowered to supervise and regulate the competition among rival health plans, especially the information provided by prospective enrollees.

The basis of competition

It is a widespread misperception that the word 'competition' implies 'price competition'. That misperception leads to the erroneous conclusion that, say, GPs in the United Kingdom or physicians in Canada, France and Germany²¹ do not compete for patients. They do compete vigorously, although not on price, which is only one or several variable on which suppliers can compete.

Countries that seek to control costs and the quality of health care through 'managed competition' should think hard about the basis of that competition. Rival health plans under that arrangement could be made to compete solely on the basis of the perceived quality of their services, but not on the premiums they receive. Alternatively, that competition could be based upon both the perceived quality of the plans and the premiums they charge. Which of these models best suits a country's health system depends on the ethical precepts that the system is to observe.

Non-price competition

Among the first formal proposals for 'managed competition' is an entry by Herman and Ann Somers (Somers and Somers, 1972; Somers, 1993). The Somers published their version of 'managed competition' long before the more recent vintages of American 'managed competition' were popularized (Enthoven, 1978; Enthoven and

21. Although individual Canadian, French and German physicians are subject to imposed fee schedules and therefore cannot compete for patients on the basis of price, they compete fiercely nevertheless, on the basis of perceived quality.

Kronick, 1989; Ellwood, Enthoven and Etheredge, 1992), and only shortly after the concept's early pioneer, Paul Ellwood (1971) had persuaded then US President Richard Nixon to propose a national health insurance system based on competition among prepaid, capitated integrated networks of health-care providers (such as the already well-established Kaiser Foundation Health Plan that had been founded by industrialist Henry Kaiser during World War II). Ellwood had christened these integrated health plans 'health maintenance organizations' (HMOs). Unlike the Somers' plan, however, Ellwood's plan did not call for a top-down global budget.

Under the Somers' plan, there would have been a national health-insurance program that would have covered the entire US population, without distinction as to income and individual contributions for health care. The program would have been supported by a single national fund, financed by a combination of different taxes. It would have been administered by a federal National Insurance Health Board. There would have been a national minimum standard of insured health benefits. Insurance coverage would be provided by competing private health plans – be they insurance carriers, group-practice plans, medical-society foundations, and so on. Among the plans would have been a government-run plan to serve as a benchmark. All Americans would have had a choice of any approved health plan in their region.

The plans themselves would not have been able to advertise directly to prospective enrollees, nor sell policies directly to individuals. Instead, easily understandable, credible and uniformly structured information on each plan would have been made available to individuals under the supervision of the National Health Board. For each family that had chosen a particular plan from the roster of available options, the Board would have paid that chosen plan, from the Board's central budget, an annual sum based on the actuarial risk represented by the insured. These actuarially adjusted premiums would have been negotiated annually with the health plans. The plans could not have charged individual enrollees additional premiums. For its part, each plan would have been free to choose the methods by which it paid the providers of health care. It also would be free to choose the managed-care techniques by which it preferred to control its overall outlays on health services.

The Somers' called their approach 'regulated competition', for that, of course, it was it was intended to be. Their plan's distinguishing feature the strict preservation of the *principle of social solidarity* that was then (in 1972) still thought to be the *sine qua non* of an acceptable universal health

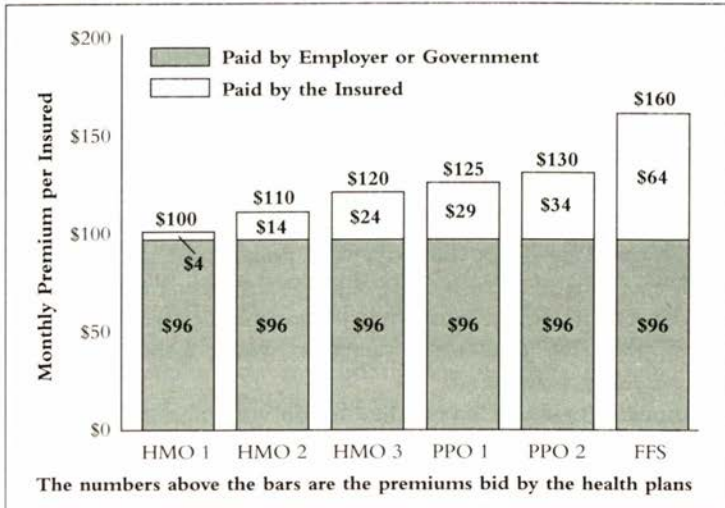
insurance system for the United States. Furthermore, the Somers' approach called for an explicit, predetermined national health-care budget, to be negotiated annually with the health plans or some representative entity of the health plans. Consequently, competition among the plans would have proceeded not on price, but only on the basis of the 'quality' of care rendered by the competing health plans. The relevant 'quality' would be that perceived by prospective enrollees, on the basis of the structured information provided on each plan.

Europeans who would like to engage market forces more imaginatively in their health systems than they do now, but who also would like to preserve their much cherished *principle of social solidarity*, might find more inspiration in the Somers' model than they are likely to find in later versions of 'managed competition' American style.

Competition on price and quality

Figure 7 is a stylized illustration of how 'managed competition' would work on the basis of both price and perceived quality. In that illustration, prospective enrollees in a market area can choose among six competing health-insurance arrangements, all bidding their premiums for a standard benefit package that has been priced out on the basis of an assumed, common actuarial risk pool. In Figure 7, these bid premiums are shown on the top of each bar. Among the plans are three classic, closed-panel HMOs with gatekeepers, two preferred-provider organizations (PPOs, basically a more loosely structured health plan without gatekeepers that offer patients a wider choice among providers at time of illness) and a classic, completely open-ended fee-for-service plan (FFS) without any limits on choice of provider. It is assumed that either the employer or the government contributes to each individual 80 per cent of a benchmark premium of \$120 per individual per month. That benchmark premium might be a weighted average of all of the premium bids submitted by the health plans or an average of the lowest N bids. An individual who enrolled in the low-cost HMO 1 would contribute out-of-pocket only \$4 per month or 4 per cent of the \$100 premium charged by these two HMOs. An individual who chose the expensive fee-for-service plan, however, would contribute out of pocket \$64 or 40 per cent of the \$160 premium charged by that plan.²²

22. In practice, there would be a risk-adjustment payment to the plans to account for differences in the actuarial risk of enrollees they had attracted under open enrollment.

Figure 7 **Managed price-competition among health plans**

With an appropriate system of subsidies for low-income families, this arrangement could provide universal coverage that gives at least a minimum floor to everyone in society, but that allows individuals with ability to pay to elect more expensive, alternative arrangements. The system would be partially income-based, but that might be tolerated by the general public if the minimum floor were judged adequate. On the other hand, in times of fiscal austerity the gap between the allowed benchmark premium and those actually charged by the plans might widen, and the tiering of health care by income class could become quite pronounced. The model is flexible on that point.

Although any synopsis of complex health-reform proposals runs the risk of doing injustice to particulars, the version of 'managed competition' advocated by the so-called Jackson-Hole Group during the health-reform debate in 1992-4 – hereafter the JHG model – comes close to the version of managed competition illustrated in Figure 7. The clearest, most comprehensive explication of the JHG plan can be found in the European *Health Economics* (Ellwood, Enthoven and Etheredge, 1992). For the most part, however, the proposal published there represents merely updated versions of the seminal papers published earlier by Ellwood (1971), Enthoven (1978) and Enthoven and Kronick (1989).

Under the JHG model and similar versions, the national health budget would be determined by the bids submitted by the competing health plans and by individual households, as they choose among the rival health plans. An advantage of this approach over the Somers' plan is that total national health spending would be driven by individual preferences, rather than bureaucratic, top-down budgeting. On the other hand, Europeans beholden to the *principle of social solidarity* might judge it amiss that this approach also is based on the individual's ability to pay. It must be emphasized again that, properly constrained, the JHG plan need not lead to a very pronounced tiering of the health-care experience by income class. On the other hand, if a more pronounced tiering by income-class were the tacit goal of health reform, then the JHG model certainly would furnish the ideal platform for such an agenda.

Although President Clinton's health plan was complex beyond the comprehension of the American public, in its central core it was an attempt to combine the chief elements of the JHG plan with those of the Somers' plan (even though the designers of the Clinton plan may not even have been aware of the Somers' plan). The financing of the plan and its reliance on both price and quality competition resembled closely the mechanism envisaged by the JHG plan. But the Clinton plan would have triggered a number of punitive strictures if the interplay between the free choices of households and the premiums bid by the rival health plans were to exceed some global national budget target. Furthermore, in the Clinton version of managed competition the regulation of health insurers (by the so-called *Health Alliances*) was far greater than that envisaged for similar organizations by the JHG,²³ which added at the time to the political drawbacks of the plan.

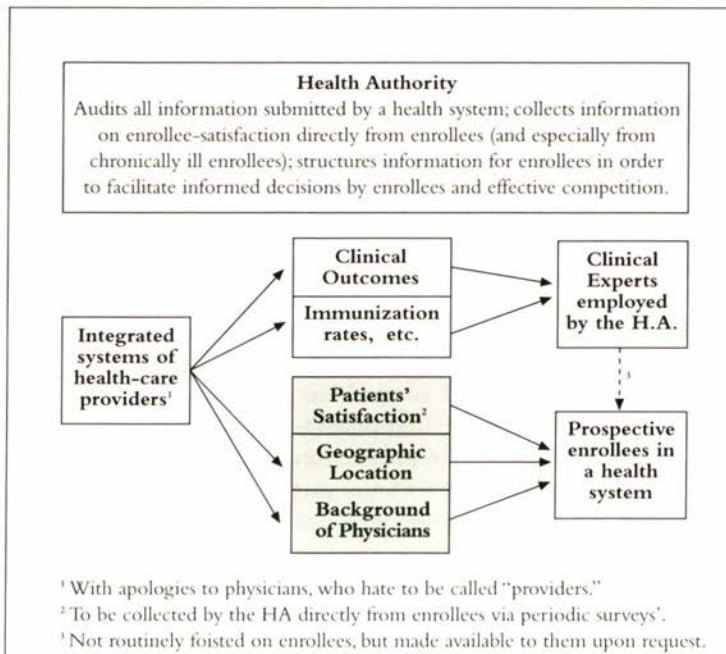
Strenuous attempts were made in the Clinton plan to provide universal health insurance coverage and to subsidize poor families adequately in their purchase of private insurance. In the end, however, the Clinton plan would have allowed at least some tiering of a family's health-care experience by income class. A certain degree of tiering by income class simply is unavoidable under versions of managed competition that let premiums paid by enrollees play a significant role in the choices by households and in cost control.

23. For a review of the Clinton health plan from a variety of perspectives, see the entire issue of *Health Affairs*, entitled 'The Clinton Plan', Spring (I), 1994.

The information infrastructure for managed competition

In general, in a well functioning market prospective customers should be able to understand the products they are being offered, which implies full disclosure of credible information about the various dimensions of these products. Ideally the information to be made available to prospective enrollees in health plans ought to be retrieved and structured by someone economically unrelated to the various health plans or networks competing with one another. In the United Kingdom, for example, that external body could be the local Health Authority (HA). If, as a second-best solution, the competitors provide that information themselves, it should be subject to rigorous external audit, as are the financial reports provided by business corporations. Figure 8 illustrates how that information infrastructure might be organized within the British context.

Figure 8 **An information system for managed competition**



Information on the clinical outcomes achieved by the competing health plans and on their epidemiological performance (i.e., the preventive-care penetration among members it achieves) would, in the first instance, go to experts who can properly assess these data. In the United Kingdom, clinical experts and epidemiologists employed by the HAs might be the proper address for such data. These data would go to lay persons only upon their request, as a matter of right.

On the other hand, it is relatively easy to retrieve and structure information on the satisfaction of enrollees already in the various competing health plans or networks. Here one would be particularly interested in satisfaction scores for chronically ill patients or those with episodes of severe illness. One should also gather information on quit rates and the reasons why families leave particular health networks. As a recent study indicated, in the United States disenrollment rates by elderly enrollees vary from a low 2.4 per cent per year in some HMOs to a high of over 80 per cent in others (Families USA Foundation, 1997; Tables 3 and 4). These disenrollment rates speak volumes. Finally, prospective enrollees would surely wish to have information about the background and experience of individual physicians in the various networks, and on the particulars of health facilities within the network. That information should be structured for easy digestion by prospective enrollees. All such information ought to be available on websites to which an increasingly computer-literate population will soon have wide access.

'Managed competition' in the United States

Europeans toying with the idea of enhanced consumer sovereignty in health care ought to attend to the construction of a solid information infrastructure first, before subjecting families to the difficult task of choosing among alternative health-care networks. Unfortunately, in the United States managed competition has been attempted in the absence of the requisite information base, which has caused widespread disillusionment with the concept and renewed calls for government regulation. For the most part, 'managed competition' as it had been envisaged by the Somers' or by the Jackson-Hole-Group has remained a mere blueprint in the United States.

To be sure, a few progressive, large business corporations (for example, the Xerox Corporation), some regional alliances of business firms (for example, the Pacific Business Group on Health in San

Francisco, or the Buyers' Health Care Action Group in Minnesota), one or two state governments (for example, the California Public Employee Retirements system [CalPERS]) and the Federal Employee Health Benefit Program (FEHB) for federal employees have made strides in providing their employees information that approximates the data sketched out in Figure 8. But these are the notable few exceptions to the rule. Furthermore, the data actually made available to prospective enrollees are still somewhat limited. For example, in the otherwise excellent *HMO Performance Report* issued by the Xerox Corporation for the 1997 open enrollment season (Xerox HealthLink, 1997), many of the HMOs listed did not provide information on consumer satisfaction rates. Remarkably, according to a notation in the report, one of the more prominent HMOs for the New Jersey region simply 'would not allow the publication of their [enrollee satisfaction] data to Xerox employees' (p.1). Apparently, the market power of the Xerox Corporation is insufficient to force such a disclosure on the insurer.

Almost half (47 per cent) of employees in the United States are offered only one health-insurance plan by their employer; another 23 per cent only two plans (Etheredge, Jones and Lewin, 1996). For the most part, the overwhelming proportion of the American population – probably over 90 per cent – basically are forced to buy their health insurance (and with it their health care) largely in the dark. Many health-insurance plans have not even bothered to establish a website that could provide prospective enrollees with basic information on patient satisfaction, on details of the medical facilities in the network, on the background of the affiliated physicians and, most important, on the particulars of the financial incentives individual physicians within the health plans have to withhold care from patients.

The political price likely to be paid for these omissions by the managed-care industry may be considerable. Last year, for example, several hundred health care bills to curb market forces were introduced in various state assemblies of the United States, only about two years after the American voters had signaled the government to get off their backs (Freudenheim, 1997; p.D2). In his column 'In Medicine, Government Rises Again', *New York Times* columnist Peter Passell concludes that 'confidence that the health care system can solve its problem without a lot of help from Washington is rapidly evaporating... Many states are regulating everything from the length of a hospital stay for a mastectomy to the financial incentives that

HMOs [health maintenance organizations] give to physicians for denying treatments. And the [US] Congress is flooded with similar ad hoc proposals from both sides of the aisle – including one from that stalwart of Republicanism, Senator Alfonse D’Amato of New York’ (1997, Sec. 4, p.1). Finally, in its draft report entitled *Consumer Bill of Rights and Responsibilities*, the *President’s Advisory Commission on Consumer Protection and Quality in Health Care* is asking for additional federal regulation of the health sector. It is a safe bet that the ‘Reregulation of American Health Care’ will be the topic of many health-care conferences in the coming year,²⁴ just as the rest of the world warms up to the soothing doctrine of ‘the market’.

The technology for a proper information system is not wanting, nor is the hardware and software that would bring ‘managed competition’ in the United States closer to the blueprints that once inspired it. Evidently, the insurance industry itself is in no hurry to provide greater transparency for more open competition. It is a safe bet that, if such transparency does emerge, it will have been foisted on the industry from without. It may be imposed by voluntary associations of private employers, such as the Pacific Business Group on Health in San Francisco or the Buyers’ Health Care Action Group in Minnesota. More probably, it will be imposed by government, through the huge public insurance programs for the elderly (Medicare) and the poor (Medicaid).

24. One will be held at Princeton University in March 1998.

VI THE AMERICAN HEALTH SYSTEM AS A ROLE MODEL FOR THE WORLD

The preceding two sections on the theory of ‘managed care’ and ‘managed competition’, and on their application in the United States, have been included in this essay to register an important point to which much of the world seems oblivious. The point is this: the much vaunted ‘managed care’ revolution that has swept the United States in recent years has been nothing more, so far, than a tentative and somewhat chaotic retreat from a quite untenable arrangement under which the prices of health services, their volume, and thus total national health spending had been virtually left to the discretion of the supply-side of the health system. In other words, utter irresponsibility in the procurement of health care has been replaced with ‘something more sensible’, something not even well understood in the United States, let alone in the rest of the world.

Even so, a few sporadic and mainly isolated local victories in hand, Americans now seem poised to export that ‘something more sensible’ abroad, with customary zeal, and in cavalier abstraction from the still glaring gap between theory and practice. Policy makers in other parts of the world must ask themselves whether the ‘something more sensible’ discovered only recently in the United States actually is ready to serve as a global role model. On this score, reasonable people could harbor some doubt.

Along with Canada and Australia, the United States is demographically the youngest country in the *Organization for Economic Cooperation and Development (OECD)*. Only after the year 2015 will the United States population attain the age structure that prevails in Europe today. Yet, even after its so-called ‘managed care revolution’, the United States continues to spend a far higher percentage of its GDP on health care (currently 14 per cent) than does any other industrialized nation (currently below 10 per cent, see Figure 1 on page 6).

Unfortunately, and quite remarkably, that high level of spending does not provide Americans with the secure health insurance that is taken for granted elsewhere in the world. The Medicare program for the elderly, for example, covers only about half of the average health spending of the aged and forces the poorest among them to devote over a third of their meager incomes to out-of-pocket spending for health care (Moon, 1996, Table 1.3, p.11). The Medicaid program for

the poor leaves uncovered roughly half of the millions of Americans living below the official poverty line. The coverage of insured Americans under age 65 is actually highly insecure as well, because it is tied to a particular job in a particular industry and is lost with that particular job. As a general rule, the typical American under age 65 has 'health-unsurance' rather than 'health insurance' (Reinhardt, 1997c).

Finally, at any moment, some 17 per cent of the American population finds itself without any health insurance whatsoever, among them some 10 million children (Rowland, Feder and Keenan, 1997; Figure 2.1, p.26). Although critically ill uninsured Americans do eventually get needed care on a charity basis – albeit in the role of health-care beggars – often these patients have lacked the timely care that could have prevented catastrophic illness. Furthermore, for all but the very poor, the care the uninsured do receive typically imposes on them stiff fiscal burdens afterwards, as they are being hounded by bill collectors for doctors and hospitals. Medical bills remain a major source of personal bankruptcy in the United States (Bleakley, 1996).

Americans can be proud of the clinical quality of most of their health care – some of which probably is the most technically sophisticated in the world – and Americans probably are second to none in the education and training of their health professionals and in medical-research. At the same time, in cross-national opinion surveys the American public regularly declares itself less satisfied with their health system overall than do respondents in other nations with their own health system (see Tables 1 and 2). In part that dissatisfaction reflects a system of financing that visits a permanent state of financial insecurity upon American families. In addition to permanent insecurity, the American system of health-care financing also visits quite extraordinary administrative costs on both patients and providers (see Table 3 further on). Measured in terms of the paper it moves – even in this electronic age – it is arguably the most complex and bureaucratic health-insurance system on earth. Finally, although physical health status measures such as infant mortality and longevity have many determinants besides health care, the United States certainly cannot claim superiority on these measures. In a press release (November 10, 1997) summarizing one of its articles (Anderson, 1997), the influential health-policy journal *Health Affairs* recently put it thus:

‘US life expectancy, infant mortality fare poorly compared to other industrialized nations; health spending leads the world.’

Yet, curiously, all over Europe and Asia one now finds congregations of local health-care managers and policy experts listening with rapt attention to American experts who, with power-book booted up and laser pointer at the ready, will walk their audiences through yet another cavalcade of America's latest health care ideas. How can one explain this fascination with a health system whose expense most of these countries simply would not tolerate and whose satisfaction rating by Americans themselves is so remarkably low?

Table 1 Ratings of health care systems in selected countries

	<i>United States</i>		<i>Canada</i>		<i>Western Germany</i>	
	<i>1988</i>	<i>1994</i>	<i>1988</i>	<i>1994</i>	<i>1988</i>	<i>1994</i>
On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better	10%	18%	56%	29%	41%	30%
There are some good things in our health care system, but fundamental changes are needed to make it work better	60%	53%	38%	59%	35%	55%
Our health care system has so much wrong with it that we need to completely rebuild it	29%	28%	5%	12%	13%	11%
Not sure	1%	1%	1%	–	11%	4%

Source: Blendon et al., 1995; Exhibit 1, p.222.

There are at least two explanations for this peculiar phenomenon.

First, whatever the American health system may represent to the average American family, to its managerial elite it furnishes a truly wondrous and richly rewarding outlet for entrepreneurial energy. Along with computers and telecommunications, it is the latest economic frontier. By contrast, the managerial elite of the Canadian and European health systems finds itself severely constrained by the

Table 2 Public attitudes towards the US health system: 1982 to 1996

	1982	84	88	90	91	93	Apr 94	Sep 94	Jan 96	Dec 96
On the whole, the health care system works pretty well and only minor changes are needed to make it work better	19	26	10	16	6	13	14	20	16	11
There are some good things about our health care system, but fundamental changes are needed to make it work better	47	49	60	59	50	49	54	44	59	52
Our health care system has so much wrong with it that we need to completely rebuild it	28	21	29	24	42	35	31	35	24	35
Not sure	6	4	1	1	2	3	1	1	1	2

Source: Blendon et al., 1997; Table 3.

principle of solidarity, by tight global budgets and by pervasive government regulation. Furthermore, by American standards health-care managers abroad are poorly paid. Canadian and European managers cannot be but impressed by the economic power, the pay and perquisites, and the exciting field of play in which their American counterparts ply their trade. 'Exporting Equity Models: UK docs targeted for investments in surgery centers', read a recent headline in *Modern Healthcare* (November 10, 1997; p.54). According to the report, a British-American joint venture will partner with UK specialists in the establishment of investor-owned surgical centers. Since 'prohibitions that doctors face in the [United] States (against self-referrals) are unlikely in the UK', continues the article, 'primary-care doctors in the UK – called GP fundholders – also could buy equity in the surgery centers'. The profit opportunities in such ventures are likely to be irresistible to many younger British physicians, nor are they incompatible with the anachronistic

Hippocratic oath that remains silent on such arrangements, because Hippocrates never even dreamt of them.

One should not be surprised that many Canadian and European managers – especially younger managers with an entrepreneurial bent and with an appreciation for the pecuniary rewards that entrepreneurship can bring – find the American health system as a far more attractive role model than their own dull systems, regardless of their system's overall performance. An enchantment with the American system is likely to be enhanced further during visits by these managers with their counterparts in the United States – visits that are much more likely to expose them to luxurious suburban hospitals and to country clubs than to the dingy and crowded emergency rooms of inner city hospitals in the United States, where rationing by long queues is *de rigeur*. Nor are the foreign visitors likely to spend time with American families driven into bankruptcy by their medical bills.

Second, however, and quite aside from the personal interest that the managerial health-care elite abroad may develop in the American experience, the extraordinary money flow into the American health sector, its permanent internal chaos, along with the rather relaxed attitude among American policy makers towards social equity makes the American health system the analogue of a generously funded laboratory unencumbered by much safety regulation. Many useful innovations can be discovered in such an unconstrained environment, and some of these are apt to be of interest even to policy makers without a personal financial stake in importing such ideas. But such a laboratory also can brew a distinct ideology, which may be imported as well, as a tie-in sale, so to speak.

To illustrate, consider the data shown in Table 3. They are from a recent, in-depth study of three health systems conducted by McKinsey & Company (1996) under the tutelage of a team of distinguished clinicians and economists (among them Nobel Laureate Kenneth Arrow of Stanford University). The McKinsey research team had followed close-up the treatment of four major tracer diseases in order to detect factors that drive cross-national differences in health spending and outcomes. With these data an attempt was made to isolate the several factors that drive the observed difference in per-capita health spending in the Germany, the United Kingdom and the United States in 1990. The study is rich and informative in detail. It should serve as a catalyst for critical self-examination in each of the countries studied--especially concerning clinical methods and

Table 3 Sources of differences in per-capita health spending

	<i>Additional health spending per-capita in the US relative to other countries*</i>	
	<i>UK</i>	<i>Germany</i>
Spending in country	\$1,113	\$1,473
Medical inputs used	\$388	(\$390)
Prices of inputs	\$686	\$737
Administration	\$437	\$360
Other	(\$185)	\$259
Spending in the US	\$2,439	\$2,439

Source: McKinsey & Co., Inc. (1996), Exhibit 5.

*1990 US dollars, purchasing power parity

outcomes. Of interest here, however, is the curious overall interpretation McKinsey & Company puts on the findings summarized in the table.

Particularly fascinating in this regard is the comparison of the German with the American health system. The McKinsey team found that in 1990 total health spending per capita in Germany (US\$1,473 in purchasing power parity) was about \$1,000 lower than that in the United States (\$2,439). Remarkably, in spite of its lower health spending overall, Germany was found to spend \$390 more per capita than did Americans on strictly medical inputs, such as hospital days, physician visits, drugs, and so on. The McKinsey team interpreted this differential as 'lower productivity' in the German health system. But who exactly benefitted from that clinical productivity gain? Did it lower the cost of American health care below German levels? It did not.

As the data in the table show, over 90 percent (\$360) of the \$390 productivity advantage claimed for the American system was absorbed by the much higher administrative complexity of the American health system. Another \$259 per capita more was spent by Americans than was spent by Germans on the catch-all category called 'Other', which may well be related to administrative complexity as well. Finally, Americans spent \$737 more per capita than did Germans in the form of higher money transfers (prices) per unit of real resource used by their health systems. While these higher money transfers may please

the providers on the supply side of the American health system who booked these transfers as income, it sorely vexes those who book these transfers as expense. Overall, then, the additional \$1,356 per capita that Americans pay for (1) higher health-care prices, (2) higher administrative costs and (2) higher 'other costs' completely swamp the \$390 Americans are said to save through the higher productivity strictly of its clinical enterprise.

In the executive summary to its report, the McKinsey team concludes that 'overall, [Germany's] regulatory constraints, coupled with the regulated per-day hospital price and lower competitive intensity, led to Germany's much higher resources use and lower productivity relative to the United States' (p.5). The team then feels emboldened to extract from that conclusion the policy insight that the US and the UK have moved in the direction of productive change of their health care system, while Germany has moved in the opposite direction (p.6). One might forgive German policy makers if they had difficulty following this line of reasoning.

For starters, a health system's 'resource use' is not just read off its clinical productivity; the term should embrace the entire spectrum of inputs, including those burned up in administration. After all, there is bound to be a trade-off between the higher administrative expense of the American health system and its lower use of strictly medical inputs, which is purchased through the expensive, hands-on techniques of micro-managing the ongoing doctor-patient relationship. We have no assurance that the United States has got that trade-off between administrative complexity and clinical productivity right. If it did, why would the overall expense of the system be so high (Figure 1 and Table 3) and the overall satisfaction of Americans with their system be so low (Tables 1 and 2)?

Earlier in this essay the point was stressed that in judging the performance of alternative health systems, terms like 'efficiency' and 'productivity' cannot be divorced from the social goals espoused with these systems. Given the distinguished advisors of the McKinsey study, is all the more remarkable that not a word is said in the report's executive summary about this important dimension of a health system. Much of the regulation inherent in the German health system was legislated for the express purpose of assuring tight cost control, which in turn makes possible a high degree of horizontal equity and a high sense of financial security for German families. It can safely be asserted that Germany towers over the United States in the attainment

of these social objectives. Health policy analysis and management consulting ought not to abstract from these important dimensions of a health system. As the trade journal *Modern Healthcare* (November 10, 1997; p.84) sagely admonishes American ‘managers, clinicians, vendors and consultants’ in a recent, unsigned editorial: ‘The Age of Imperialism is over. Other countries don't want our system shoved down their throats... Learning about the customs, values and habits of the host country is a must’ (Emphasis added).

These remarks are not intended to belittle the contribution that American ideas about health care can make to the rest of the world. In their missionary forays abroad, American health experts may be selling their audiences one, some or all of the following innovations for health care:

1. strictly clinical innovations;
2. new methods to define, measure, monitor and control the clinical quality of health care;
3. new methods to control the real resource cost of medical treatments;
4. new methods to reduce the money-transfer into the health system per unit of real resource; but also
5. a new ideology of sharing the fiscal burden of ill health – that is, a new social ethic for health care.

Useful contributions may be offered by American experts under each of these rubrics. As noted, the McKinsey study certainly should trigger, in Germany, some soul searching on clinical efficacy and, in the United States, on administrative efficacy. But just as there is such a thing as ‘safe sex’ – intended to protect its practitioners from a bodily invasion by dangerous viruses – there must be something like ‘safe health policy’ – intended to protect entire health systems from infection by the virus of an alien social ethic. At a minimum, the practice of ‘safe health policy’ would require foreign experts (whatever their origin) to preambule their presentations with an explicit statement on the distributive ethic packaged into their normative prescriptions, lest they export in the seemingly value-free mantles of ‘efficiency’ and ‘productivity’ a distributive ethic distinctly at variance with their hosts’ cultural norms.

VII THE POTENTIAL FOR MANAGED COMPETITION IN THE UNITED KINGDOM

In reviewing former Prime Minister Margaret Thatcher's 'big bang health care reform' of 1991 for an American readership, Rudolf Klein (1995) boldly asserts that 'in a global sense, the NHS [has] provided a most efficient service; compared with most other health systems, it provided a remarkably comprehensive service at a remarkably reasonable price' (p.309). That assertion will grate on the many Americans who for years have used the NHS as the bogeyman of 'socialized medicine'. But given the specific social goals posed for the NHS which, in turn, determine how the British define 'value' in health care, could Americans demonstrate that their health system is more efficient than the British system? On the American lecture circuit, 'value' in health care is regularly defined as 'quality over cost'. On that definition of 'value', the NHS may well beat the American health system hands down.

Klein is quick to concede, however, that 'in detail, the NHS [has] provided endless examples of inefficiency or poor productivity' (p.309). The same point has been made by other students of the NHS (see, for example, Maynard, 1994; p.1435). Klein observes further that 'professional paternalism is still, in most spheres, the norm' in the NHS, even in the age of world-wide consumer activism (p.317). To quote him at length on this point:

Inherent in the NHS's linguistic transformation of the patient into a consumer is a curious paradox. This is that the new rhetoric of consumerism is a response to top-down policies rather than bottom-up demands. The post 1991 NHS, like the pre-1991 NHS, does not have consumers in a strict sense: that is people able to choose what they want. For the reforms have conspicuously failed to achieve the government's objective, as set out in *Working for Patients*, of giving patients 'greater choice of the services available'... The dynamics of the new-model NHS are driven not by consumers but by purchasers: health authorities and fundholding GPs have become proxy consumers... To the extent that the government's program of action was designed to give patients greater choice, it must therefore be rated a failure (pp.317-8).

As Alan Maynard has put it, in the end the 1991 reforms resulted not in a more efficient competitive market, but in 'quasi-centralized

bureaucratic confusion dressed up in the rhetoric of competition' (Maynard, 1994).

The parallel with the American experience in this regard is as striking as it is ironic. In the United States, as in the United Kingdom, the much vaunted 'consumer-choice' revolution that is said to lie at the heart of the country's 'managed-care revolution' was not at all an answer to the prayers of American families, chewing at the bit for a more constructive role in controlling health care. On the contrary, to the individual American that 'consumer choice' revolution has manifested itself in sharply restricted choice, imposed top-down by the American analogue of the British local Health Authority (HA): the powerful, paternalistic employer who controls the economic base of the typical American family, along with the family's health insurance coverage.

In theory, the new American health system was to afford employees a well-informed choice among several competing private health plans that would, in effect, become the employees' private health-care regulators. In practice, as was noted earlier, the typical American was thrust blind-folded into a raw, commercial free-for-all among the would-be private regulators for the cash flows that 'insured lives' could yield these private regulators.²⁵ With very few exceptions – notably in California – the typical American today knows no more about the quality of the health-care regulation likely to be performed by competing health plans than do British individuals about the health-care regulation likely to be performed by competing GP-fundholders. It is the reason why Americans now beg the federal and state governments for increased government-regulation of the private health-care regulators. In so doing, they are reacting angrily to an alleged 'consumer-choice' revolution that put the cart (competition) before the horse (disclosure of pertinent information).

Because the idea of consumer-driven control over health care has so far remained a lovely theory that has stumbled badly on the road to implementation, policy makers everywhere are left with the following

25. 'Insured lives' is a widely used term for 'enrollees in a health plan'. The price of a health plan on Wall Street, for example, typically is expressed as '\$X per insured life', where X in recent years has fluctuated between \$600 and \$1,500. That price is the present (discounted) value of the future net cash profit flow that the purchaser of the health plan expects to extract from an 'insured life'.

fundamental questions:

1. To what extent can the self-interest of individuals, in their role as 'consumers' and as 'patients', actually be enlisted to force on the providers of health care greater accountability for the real and financial resources they conscript?
2. Can consumer-driven accountability be achieved without letting the health-care experience of individuals be tiered noticeably by income class?
3. If not, is tiering of health care by income class a price worth paying for consumer-driven cost- and quality-control in health care, or should providers be held more fully accountable for their decisions through alternative means?

Lurking behind these question is the further question at what point a healthy 'consumer' who, in Rudolf Klein's perceptive imagery (Klein, 1995; p.327), calmly and rationally views the health system merely as a repair garage, metamorphoses into to a seriously ill 'patient' who anxiously views the health system as something like a church and the doctor as someone like a priest.

Consumer-driven price competition

One reason why the march towards managed competition in the United States has been reduced to mere stumbling is that the development of the requisite information infrastructure ultimately will require the creation of a new quasi-public authority, a 'Health Alliance' as it was called in the Clinton Plan. Large employers may be able to function as their own Health Alliance; smaller employers may be able to organize an Alliance jointly for their members. In the end, however, a plethora of independent health-care alliances would be likely to be less effective and less transparent than one that is publicly chartered by the state government and charged to monitor all health plans offering coverage within the state.

As noted earlier, a major task of such an entity would be to retrieve information on consumers' satisfaction and the clinical quality of care delivered by health plans, to structure the information in a form that is usable by the average consumer, and to disseminate the structured information through various channels, including the Internet. To avoid the moral hazard inherent in data that are self-reported by the competing health plans, the Health Alliance should retrieve these data directly from enrollees. It follows that, from the perspective of the

American managed-care industry, the creation of a properly functioning information infrastructure for managed competition would pull the insurance industry back from the current, relatively unfettered free-for-all into a more regulated, orderly market. Therefore it is not surprising that there has been so little progress on this front. On the contrary, it is to be expected that the managed-care industry will retard as long as possible the establishment of the full transparency that that consumers need but that the industry seems to fear.

In this respect, the British health system may have a distinct advantage over the United States, because managed competition in the United Kingdom would represent a loosening, rather than a tightening, of the regulator's hold on the system. In theory, at least, it might be possible to experiment in the United Kingdom with a broadened concept of GP-fundholding, that is, with the establishment of cooperative, economically and clinically integrated networks or systems of primary care facilities, hospital trusts, pharmacies and other health-care facilities that would be capable of delivering the entire spectrum of medically necessary health services against prepaid, risk-adjusted capitation payments.²⁶ If such experiments bore fruit, the health-care delivery system in a health district could eventually be sliced up into a number of such networks that would be made to compete for enrollees under the supervision of the Health Authority (HA). In effect, the HA would become a full-fledged Health Alliance that would operate a fairly sophisticated information system, such as that sketched out in Figure 8 on page 45. If competition were meant to be consumer-driven, then the HA would also face the task of making sure that families in every region actually had a choice among several competing health-care networks or systems.

In such a system, the HA would manage the flow of public funds to the competing health networks. A fundamental question for public policy then would be how much financial risk could safely be heaped upon the individual competing networks. Would a network be

26. In the United States, a model of this version of managed competition, in which networks of health-care providers (rather than health-insurance plans) offer themselves directly to prospective enrollees is currently under development by the Minnesota Buyers' Health Care Action Group (BHCAG).

allowed to go bankrupt and dissolve, as is the case now in the United States? Another problematic facet of managing the flow of funds would be the need for fair adjustment of the capitation payments for the risk-pool actually attracted by the individual networks. Here it must be conceded that no country has as yet developed risk adjusters that are up to this essential task. There would, therefore, remain a strong incentive for the health networks to skim the actuarial cream during the periodic open enrollment seasons. If risk adjustment is not perfect, then being first-rate in the treatment of serious chronic diseases is actually a disadvantage for a competing health network, as it might end up with expensive patients for which it is not adequately compensated.²⁷

Finally, yet another crucial design question for this policy would be whether or not the competing health networks could collect from enrollees premiums in addition to those received from public sources. As noted earlier, selecting the basis of competition would be one of the more crucial policy decisions. Because it touches on the fundamental issue of social ethics, that decision should be made consciously, after open debate.

Competition on the basis only of quality – described earlier as the Somers’ model – would preserve perfect horizontal equity in the financing of health care (if not necessarily in the receipt of services). Even under this approach, the system would be more pluralistic than the present NHS, although consumers’ ability to pay would not be the driver of that pluralism any more than it is now. Because this approach would not permit payments by consumers to the networks, in addition to the publicly funded capitation, it would also facilitate airtight, top-down global budgeting on a national and local level.

The second approach – described earlier as the JHG model – would permit consumers to pay a chosen network a premium in addition to the publicly funded capitation. This system would not preserve perfect horizontal equity in the financing of health care; the pluralism of the health system would be partially driven by differential ability to pay. Furthermore, it would not be possible under that approach to impose a tight global budget on the health system. Indeed, the *raison d’être* of

27. An adage sometimes jokingly quoted among American HMOs is that the first-best policy in this regard is to be third best in the treatment of expensive chronic diseases, such as AIDS.

this approach would be to avoid the imposition of a global budget on the system.

Evidently, the evolution of the NHS toward this form of consumer-driven, managed price-competition would be a revolutionary departure from the present structure of the NHS, one even the Thatcher government did not have the temerity to attempt. If one were really serious about pitting rival health-care networks against one another in a competitive fray, marketing and administration would absorb an increasing fraction of total premiums paid (Healthcare 2000, 1995; p.11). Among American HMOs, these costs now absorb anywhere from 10 to 30 per cent of premiums paid (in this connection, see also Table 3 above). They now support an entirely new and far flung industry of management, financial and marketing consultants. In the United States, however, some of these high administrative costs could be financed, at least for a while, out of the reductions in the money transfers to providers (relative to projected transfers) that were achieved during 1992-96. They represented a redistribution of income from providers to consultants, not from patients to consultants. That huge financial reserve for the financing of higher administrative costs is not present in the British system. In the NHS, higher administrative costs would spell either higher taxes or, more likely, fewer medical inputs. The question therefore arises whether the organizational disruption and the additional huge administrative expense associated with this form of competition could be justified by the net benefits they might yield for British patients and taxpayers.

Here it must be emphasized again that, at this time, the consumer-driven version of managed price-competition American style remains a largely untested theory for which almost any desired empirical evidence, pro or con, could be adduced with appeal to local American experiences. Remarkably, in spite of the importance of the idea, and the global fascination with it, there has been little systematic research on the ability of individuals in different socio-economic and demographic groups to act sensibly on the plethora of information that might be thrown at them under full-fledged managed competition.

Specifically, it is not known whether the average individual will be able to digest and react sensibly to information on the clinical and epidemiological quality of care given by competing health plans or to information on the performance of individual physicians and

hospitals.²⁸ The state of Pennsylvania, for example, publishes annually detailed information on the statistically expected mortality rate and the actual mortality rate from coronary bypass grafts performed in the state. These data, which are published in the daily press, are disaggregated to the level of the individual surgeon and hospital, and they include the individual hospital's provider's average charge for the procedure. It is not known if and how these data influence the decisions of prospective patients or of the HMOs in the state. Indeed, a recent study suggests that the data are disregarded even by cardiologists in their referral decisions, presumably because the cardiologists have no faith in the validity of the data (Schneider and Epstein, 1996).

In the end, after the careful research, it may yet be discovered that the choices made by individuals can control only the sundry factors that drive 'consumer satisfaction', and that these factors are distinct from 'quality' as it would be perceived by clinical experts and epidemiologists. If so, effective quality- and cost control would have to rely mainly on the financial penalties and rewards that could be dished out by more expert purchasers of health care (or, as will be suggested below, on professional norms and professional pride). In the United States, the expert purchaser who could reward and punish providers financially would be government agencies, private employers or HMOs engaged by government and employers. In the United Kingdom, they could be the HAs or, alternatively, primary-care networks purchasing health care on behalf of enrolled populations. Once again, however, unlike policy makers in the United States, their colleagues in the United Kingdom might not have the temerity actually to visit on individual networks of providers fiscal punishment to the point of their extinction. The tolerable limit might be merely some fiscal discomfort.

28. Because it is not clear from the available research how employees react to detailed information on health plans, the Xerox Corporation actually pays employees a reward for choosing HMOs that the firm views as superior on the criterion of clinical and epidemiological performance. Such rewards betrays a lack of faith in the employees's ability to react properly to the entire range of information.

Accountability through professional norms

If there are cultural or political limits to the degree of fiscal reward and punishment that can be visited upon the providers of health care or, as it may turn out, these rewards and punishments are found to work perversely in practice, then appeal to professional pride or civic integrity may be an alternative method of eliciting from providers better accountability for their work. With modern information technology, these drivers of competition among professionals could probably be better exploited than they have been so far. While there is scant evidence in the United States on the response of consumers to information about health plans or individual providers of healthcare, there is at least some evidence that physicians will react constructively to published information on deviations of their own practice profiles from established norms. Summarizing an early study of the feedback approach practiced by the medical association of the State of Maine, Caper, Keller and Rohlfs (1986) concluded that

Collectively, the experience in Maine demonstrates that physicians, approached in reasonable fashion with sound information, will listen, learn and examine their practice patterns, altering their practice style if necessary. It also shows that peer pressure, exercised judiciously by respected leaders willing to commit their time and expertise, can be an effective influence within the medical profession. This [feedback] approach gives physicians an opportunity to play a constructive role in improving the efficiency and productivity of health care (p.9).

Experience with the professional feedback model in the United States encourages one to think that, even in the absence of full-fledged, consumer-driven, managed price-competition, the HAs of the NHS could make individual professionals and entire health facilities within the district more fully accountable for their use of resources, if their practice patterns were regularly and systematically held up to the professional norms suggested by evidence-based medicine and by the opportunity costs implicit in the funding of the NHS. With the same technique, the central administration of the NHS also could hold individual HAs more fully to account than appears to have been the practice so far.

That accounting could be rendered with varying degrees of publicity. At the local level, it could remain a private communication

between the HA and the individual practitioner or health facility. Even that limited broadcast probably would engage professional curiosity and pride. Alternatively, the data could be broadcast more openly within the entire peer group of health care providers, to engage professional pride more forcefully. Finally, through the Internet the data might even be made accessible to the public and be published in the media, as sometimes it is in the United States.

In the United Kingdom, accountability with the help of professional norms and with appeal to professional pride may yield dividends more quickly and more safely than might full-fledged consumer-driven managed competition American style, that is, competition based not only on 'quality' as it is perceived by prospective enrollees (the Somers' model), but also on premiums borne directly by enrollees (the JHG model). Managed price-competition American style might inexorably erode the social contract under which the NHS has hitherto functioned and that still seems to be cherished in Britain and elsewhere in Europe (de Gooijer, 1997).

Interface between the NHS and the private system

There is the further question to what extent the NHS budget ought to be the final word on total national health spending in the United Kingdom (Dixon, Harrison and New, 1997; Towse, 1995; Jones and Duncan; 1995; Healthcare 2000, 1995). Most nations with universal health-insurance coverage do permit families who can afford it to purchase private health insurance that bestows upon the insured a variety of real or imagined superior health-care benefits. As the income distributions throughout the industrialized words continue to spread apart, that migration to private coverage may pick up pace. The trend raises two fundamental questions. First, should that trend be permitted in the first place (see, for example, Hoffmeyer and McCarthy 1994). Second, if so, how should the private and public sector be stitched together?

Nations that do operate both private and public health sectors usually try to erect between the two systems a wall that prohibits easy migration to and fro. To illustrate, slightly over 10 per cent of the German population has comprehensive private health insurance. The remainder are fully covered under the statutory system, although some of the latter may have supplementary private insurance coverage that

pays for private rooms in the hospital and similar amenities. Below a certain income level Germans must belong to the statutory system. Above that income level they may elect the private system but, having done so, cannot ever return to the statutory system. Privately insured patients enjoy private rooms in hospitals and are entitled to be treated by the *Chefarzt* (the chief medical officer of the relevant hospital department). On an ambulatory basis privately insured patients see the same physicians as do those covered by the statutory system, although they may well be granted scheduled appointments, somewhat longer office visits and similar amenities. Their use of prescription drugs is identical with that of patients in the statutory system.

Like their British counterparts, German hospitals and physicians treat patients in either insurance system. On the other hand, the insured in Germany are covered fully by either the private or the public system. Unlike their British counterparts, they cannot straddle both insurance systems (aside from the supplementary coverage for amenities).

In this respect, Canada is even more restrictive. Virtually the entire population is covered by the public health-insurance systems operated by the provincial governments, and virtually all revenue flows to doctors and hospitals come from the provincial plans. In principle, a Canadian citizen could elect to stay outside the public system, in which case he or she would be responsible for financing personally all health care received from any source. Similarly, a Canadian physician could, in principle, stay outside of the public insurance system, but then he or she would be 100 per cent outside that system and could never be compensated by it for any service. Practically, the United States health system functions as the only private delivery system available to Canadians, some of whom do travel to the United States there to procure with their own resources health care either not available in Canada or available only by queuing up for it.

Even in the United States, which is generally quite hospitable to private enterprise in health care, it has so far remained illegal for physicians and patients to contract privately for the provision of services that are already covered by the Medicare program for the elderly. For these services, physicians must accept Medicare's scheduled fees (and hospitals likewise). The elderly may purchase private, supplementary insurance coverage only for the cost-sharing the program imposes on them or for services (such as prescription drugs) that are not covered by Medicare. It is no small irony that

American physicians and legislators who would like to permit ad-hoc private contracting between the elderly and their physicians, on a patient-by-patient and service-by-service basis, point to the United Kingdom as a model for this more liberal approach.

In the United Kingdom, private health spending outside the NHS has remained fairly stable at around 15 per cent since 1985 (Office of Health Economics, 1997; Table 2.5), although private health insurance premiums proper apparently represent only about 4 per cent of total NHS spending (Maynard and Bloor, 1996; p.604). Furthermore, private insurance represents merely supplemental coverage for elective procedures, in addition to universal NHS coverage which covers the same procedures as well. This arrangement effectively permits the same individual to procure certain health services (e.g., elective surgical procedures) either as a publicly insured patient under the NHS, or as a private patient. Furthermore, it permits physicians to treat patients either as salaried employees of the NHS or as private practitioners paid fee-for-service. This ad hoc approach is one of many approaches to a partial privatization of the health system, but one whose merits one could debate.

An analogy from education may be useful. Parents in the United States are free to send their children either to private schools and universities or to publicly funded institutions. Many parents with the means to finance a private education elect to do so. So far, however, they have not been excused from paying property or general taxes used to fund public education system.²⁹ Consider now a publicly funded state university in the United States that charges students only nominal tuition. If it were ever proposed by professors at such a university that they could claim or feign an overcrowded appointment calendar during regular office hours, but stood ready to see their students, for a private fee, at private tutoring sessions on the weekend, such a practice would trigger a public outrage even in the United States, with its traditional high tolerance for the private-market initiatives. Yet, is the medical analogue of this practice not eminently feasible now under the British health-insurance system?

29. For decades there have been proposals to issue parents publicly financed vouchers with which they could procure for their children either a private or a public education. But because private schools institutions would be free to charge tuition in addition to the voucher, that idea so far has not gained popular support.

This ad hoc approach to privatization may find public acceptance as long as the volume of border crossing remains relatively small. One could then view it as a relatively innocuous method of supplementing the incomes of physicians and, at the same time, of shortening queues for elective procedures. The question is how that system would fare if the NHS budget remained tightly controlled in the future and the private insurance sector grew more rapidly as a result. The approach also will be increasingly tested as British and American entrepreneurs learn to enlist more extensively than they have so far the latent interest of British physicians – especially younger physicians – in investing in freestanding commercial clinics and surgical centers. An arrangement that offers physicians and hospitals the incentive of nudging patients from NHS coverage for particular procedures to financially more rewarding treatment under private coverage sets the entire health-insurance system upon a slippery slope that may eventually end up in the appearance of impropriety, if not in outright impropriety.

A less problematic approach might be to erect a higher wall between the two systems. This could easiest be done by requiring providers to work either entirely within or entirely outside the NHS. Alternatively, it could be done by creating private health-insurance for fully comprehensive coverage, with the aim of providing coverage for a particular patient and for a particular service by only one insurance system, and not both. Finally, one cannot but agree with Maynard and Sheldon (1997) that an accountable health systems would require a meticulous accounting for the time the individual physician actually devotes to the public and to the private system. It also would require full disclosure of any financial ties that physicians may have to private facilities to which they might refer their patients.

VIII CONCLUDING REMARKS: WHITHER HEALTH CARE?

At the beginning of this essay, it was remarked that the current world wide malaise over health care is nothing new, and that it will never abate. At the heart of that malaise lies the perennial suspicion that the health sector does not use the resources entrusted to it as well as it might, because the transactions in the health sector typically lack the economic legitimacy that makes normal transactions in the market place so civilized and mutually agreeable. Unfortunately, there does not exist an arrangement that could ever raise the typical health care transaction to that level of economic legitimacy. Therefore, permanent unhappiness with the health system is part and parcel of the human condition, as are the periodic calls for bold reforms that are followed periodically by feeble attempts at reform, only to be followed by further calls for reform.

The current, worldwide epidemic of health-care reform, as Rudolf Klein (1995) has called it, is driven by one common objective: to hold physicians and the managers of health care facilities more fully accountable for the resources they are allocated (as under the British system) or that they conscript (as in many other systems). For many decades that call for accountability had been muted. Perhaps this was so because policy makers believed medical practice to be based on a solid body of rigorously tested medical theories, and assumed that a strict code of medical ethics and a civic spirit would make physicians mindful of the opportunity cost of resources used in the application of their medical theories. Furthermore, however, the information technology required for more systematic accountability had not yet been developed. Until recently, it was crude and very expensive.

Three major trends have converged to raise to chorus for better accountability on health care to a crescendo.

First, health care everywhere has absorbed an ever larger share of the GDP. That trend in itself has triggered a call for better accountability in health care, as policy makers and the general public seek assurance that the incremental resources they are asked to divert to health care will yield commensurate benefits. Some observers believe that ever higher health spending, per capita or as a percentage of the GDP, is the inevitable product of macro-economic arithmetic. This prediction rests on the thesis that the health sector cannot match the secular productivity trends in other sectors of the economy (Baumol, 1996) and therefore will lay an ever larger claim on total

GDP. Although the general thesis of a productivity gap in health care is not easily dismissed, it is severely dented by the enormous intra-national and international variations in health-spending per capita, without visible reflection in health status. At the very least, these practice variations cast doubt on the size of the productivity gap posited by Baumol. For example, if physicians in the state of Florida could be induced to adopt, over time, the practice patterns of their colleagues in Minnesota, the health system in Florida could be booking productivity gains for years to come. In many parts of the world – though perhaps not in the United Kingdom – talk about the inevitability of rising health spending seems premature.

The growing body of scientific research on these clinical practice variations is the second major trend driving calls for greater accountability in health care. Because the medical profession has not been able to justify these glaring differentials, the question no longer is whether more effective accountability should be imposed on the health system. The question is who should be held accountable, and how?

Finally, the third major trend pushing calls for greater accountability in health care is the remarkable decline in the cost of processing information, coupled with a growing sophistication among policy analysts and policy makers to use the structured information produced by modern information technology. Although health-care accounting is yet to develop into the mature analogue of financial accounting, there is little doubt that the discipline will develop in the decades ahead and will impose itself forcefully on health care.

While the idea to impose greater accountability on the supply side of the health-care sector is now uncontroversial – certainly outside the health sector – there is considerable debate on the role that the recipients of health care should play in this process. Indeed, there is debate on whether these recipients are best viewed as ‘patients’ or ‘consumers’. That distinction is not trivial, for the names imply different roles.

Three distinct theoretical models concerning the role of the recipients of health care now vie for the policy maker’s attention.

The first of these models is driven by the belief that the health sector will never act responsibly unless the recipients of health care themselves force it to do so. A felicitous label for this approach is the ‘consumer-sovereignty model’ or the ‘consumer-empowerment model’. A less marketable imagery is that ‘consumers’ should be made

to bear acute fiscal discomfort at the very time that they suffer acute physical discomfort. Only then, it is thought, will the health care sector be subjected to the careful benefit-cost calculus that is the *sine qua non* of 'efficiency' elsewhere in the economy. The previously cited proposal by the American Nobel Laureate economist Milton Friedman falls into that category of models, as do the various proposals now lumped together under the heading of 'medical savings accounts' (MSAs). Characteristic of these models is very substantial sharing of the cost of health care by patients at the time health care is received. That cost sharing takes the form of high deductibles, along with substantial coinsurance once the deductible has been met and insurance coverage sets in. While this model has as yet little currency in Europe, it is popular among policy makers in the United States and in Asia.

The second category of health-reform models rests on the thesis that, because most health spending is triggered by relatively sick people, the demand side of the health care market cannot ever be adequately staffed by 'patients'. This thesis is based on the belief that, even under the best of times, lay persons do not possess the clinical know-how required to make rational choices among medical treatments, and that they could do so at most in close cooperation with physicians (Wennberg, 1990; pp.37-8). Furthermore, the idea to force aching, frightened and possibly dying individuals into an economic benefit-cost calculus at the time of their travails seems uncivilized to this school of thought. Here it must be noted that, in a modern health system, between 70 to 80 per cent of all health spending in any given year is booked on the head of only about 10 per cent of the population who must be presumed to be seriously ill (Berk and Monheit, 1992).

On the other hand, this second school of thought does believe that the demand side could be strongly influenced by prospective patients ('consumers'), if they could be made to choose among professional, private health-care regulators who are forced to compete for the prospective patients' prepaid health-care budgets (capitation payments) and who are then entrusted with 'managing' the health care of the individuals whose chose them. These private regulators could be HMOs or other health plans. They could also be networks of health care providers orchestrated by primary health care professionals – a model of health-care regulation favored in the United Kingdom. The Somers' and JHG models described in Section IV fall

into this category of models.

Finally, a third category of health-reform models would excuse (or eclipse) the individual from active participation in cost and quality control in health care. Instead of allowing or forcing the individual to choose from a menu of competing private health-care regulators, this model would simply assign individuals to a private or public regulator who would be charged with the task of 'managing' health care on behalf of patients and act as a purchasing agent on behalf of patients. To force responsibility on the providers from whom health care is purchased, this private or public regulator might visit powerful fiscal penalties on providers who deviate from established practice norms – an application of the famous technique of management by exception. Alternatively, the private or public regulators could seek adherence to established norms by appealing to professional pride, simply by publishing the actual practice patterns of individual providers.

The White Paper for England *The New NHS* (Department of Health, 1997) recently issued by Prime Minister Blair appears to embody this third model explicitly, for the primary-care networks to be entrusted with managing and commissioning health care would be local monopolies in health-care regulation. The GP-fundholding model introduced by the previous government bordered on that model as well, if not *de jure*, then *de facto*. Although, in theory, that model had contemplated consumer choice, apparently it never bothered to develop the basic information infrastructure that would have offered the individual an informed choice among GP-fundholders. It was not a sincere attempt at consumer-driven, managed competition.

Evidently, these distinct, alternative approaches to seeking greater accountability in health care differ not only in their beliefs about what choices the individual can and cannot properly make in health care. These models also differ in the incidence of the fiscal burden of illness – in the distributive ethic they would impose on the health system. For that reason, these models cannot easily be compared in terms of their relative 'efficiency'. As was noted at length in Section III, the word 'efficiency' in health care is meaningless in abstraction from a clearly articulated distributive ethic.

The current wave of health reforms happens to coincide with the rapid globalization of commerce which, along with technological change, has served to spread considerable the distribution of income throughout the industrialized world (*The Economist*, November 5,

1995). Under these circumstances, the most fundamental question confronting health-policy makers in Canada and in Europe is how long they will be able to hold the nations' health systems to the *principle of social solidarity* that has hitherto guided these systems. Bluntly put, the question is whether families comfortably ensconced in the upper third of the nation's income distribution will continue to be willing to help finance for families in the lower third quite the luxury and technical sophistication of health care that families in the upper third would like to purchase for themselves. A related question is to what extent chronically healthy people should be made to subsidize chronically sick people. At the level of concrete health policy, these questions translate into the issue to what extent the rationing of health care among individuals should be based on the individual's ability to pay.

A major theme running through this essay has been that airing this question is not a source of shame. It is a legitimate question that deserves candid debate and, ultimately, a democratic resolution. Highly questionable, as noted, is the practice of letting this important question be resolved implicitly, but inexorably, through reforms that march under the banner of 'the market' or of 'greater efficiency', without explicit attention to the distributional effects of these reforms. With careful government regulation and ever vigilant oversight, the power of market forces can be grafted more fully than they have been onto the *principle of solidarity*, to achieve greater 'efficiency', properly defined in terms of the goal of social solidarity. But the freer the market – the more unregulated its legendary Invisible Hand – the greater will be the health system's departure from social solidarity. Whether or not that is desirable is not a question for economists to answer. It revolves around two fundamental questions that only a political algorithm can resolve.

For one, there is the question about the preferred role of 'health care' in society. One can envisage at least three distinct roles, to wit:

- (a) Health care should be treated a purely social good available to all members of society, on equal terms, regardless of the individual's ability to pay for it.
- (b) Health care should be treated as a purely social good for the bulk of the population, but as purely private good available to the 'moneyed elite' (say, families in the top decile of the nation's income distribution) on superior terms and in superior quantity, either through private purchase outright or through

privately purchased and unsubsidized health insurance.

- (c) Health care should be viewed like any other basic necessity – such as food, clothing and housing – of which a very minimal ration ought to be guaranteed everyone in society, but which is rationed primarily by price and the individual's ability to pay.

As I have argued elsewhere (Reinhardt, 1996a), the American policy-making elite appears to have shifted more and more to the third view, although it is not clear that the general public concurs at this time.

Part of the problem of choosing among these distinct visions for health care, of course, is the wide embrace of the term 'health care'. This raises a related question, namely, does the term 'health care' include anything that the health-care sector might conceivably supply, including, say, hair transplants and fertility counseling, which are included in the government-mandated insurance-benefit packages of some US states? Or is it possible to segment what a health system can do into those goods and services that ought to be treated as purely private consumer goods and those that ought to be viewed as purely social goods, with perhaps other categories in between? Many countries, the United Kingdom included, have been reluctant to tackle this thorny question explicitly. Its resolution remains a major item on the agenda of policy makers everywhere.

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