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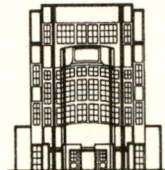
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TO: Richard Porter

FROM: Lisa S. Krueger, Assistant Director
(609) 258-5765

RE: Logistical Details

DATE: May 6, 1992

I enclose an updated program for the upcoming CEPS Symposium with precise times and locations for all events on May 15-16. Please note several minor changes, including a 6:30 p.m. start time for cocktails on Friday evening, followed by dinner at 7:30 p.m. in the Garden Room at Prospect House on the University campus. A map, indicating the location of Prospect and the Nassau Inn, is also enclosed. If you need more detailed directions to the Princeton area, please feel free to give me a call.

We look forward to seeing you on May 15-16.

Encls.

Program
CEPS Symposium
Princeton, May 15-16, 1992
Reforming America's Health Care System

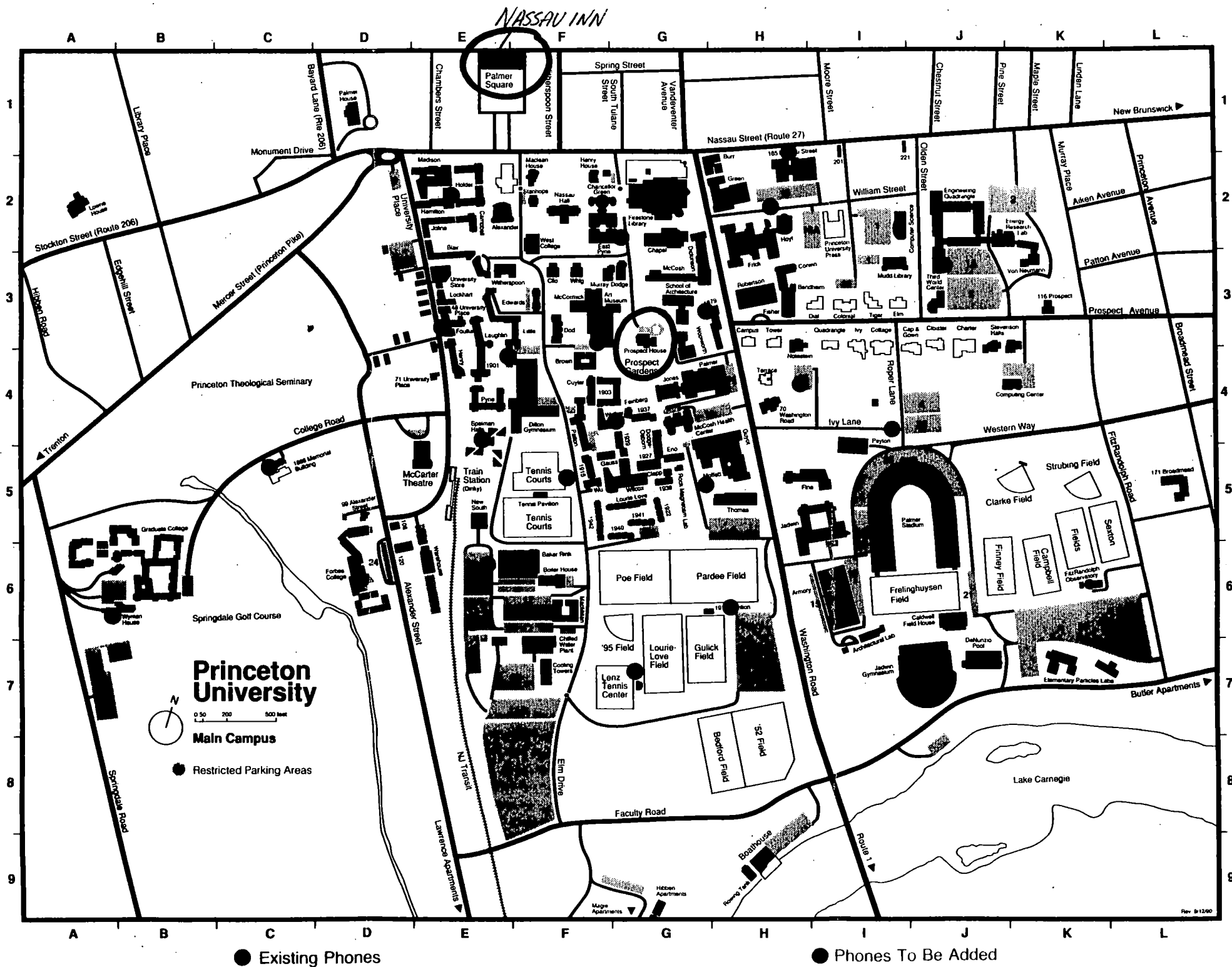
Friday, May 15: Prospect House

- 6:30 P.M. Cocktails
- 7:30 P.M. Dinner followed by address by **Joseph Califano**
(Dewey, Ballantine; former Secretary of Health,
Education and Welfare)

Saturday, May 16: Nassau Room, Nassau Inn

- 9:00 A.M. Welcoming Remarks: **Harvey Rosen**
- 9:05 A.M. U.S. Health Care: The Facts and International Comparisons

Uwe Reinhardt (James Madison Professor of Political Economy, Princeton University)
Harold Shapiro (President and Professor of Economics and Public Policy, Princeton University)
- 10:00 A.M. Rising Medical Costs: A Physician's Perspective
Steven Schroeder (President, Robert Wood Johnson Foundation)
- 10:30 A.M. Coffee Break
- 10:50 A.M. Health Care Reform: The Administration's View
Gail Wilensky (Deputy Assistant to the President for Policy Development)
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- 12:30 P.M. Lunch - Palmer's, Nassau Inn
- 1:50 P.M. Panel on Health Care Provision: What Works and What Doesn't?
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Samuel Havens (Senior Vice President, Prudential Insurance Company)
Paul Starr (Professor of Sociology, Princeton University)
- 3:00-4:00 Panel on The Politics and Economics of Health Care Reform
Uwe Reinhardt, Chair
John Hilley (Chief of Staff for Senator George Mitchell)
Walter Maher (Director-Federal Relations, Chrysler Corporation)
- 4:00 P.M. Light Refreshments and Informal Discussion



PRINCETON UNIVERSITY

Alexander Hall, E2
 Architectural Lab, I7
 Architecture, School of, G3
 Armory, I6
 Art Museum, F3
 Baker Rink, F6
 Bendheim, H3
 Blair, E3
 Boathouse, H9
 Brown, F4
 Burr, H2
 Butler Apartments, L7
 Caldwell Field House, J6
 Campbell, E2
 Chancellor Green
 Center, F2
 Chapel, G2
 Clapp, G5
 Class of 1901, E4
 Class of 1903, F4
 Class of 1904–Henry, E4
 Class of 1905–Foulke, E3
 Class of 1915, F5
 Class of 1922, G5
 Class of 1927–Clapp, G5
 Class of 1937, G4
 Class of 1938, G5
 Class of 1939, G5
 Class of 1940, G5
 Class of 1941, G5
 Class of 1942, F5
 Clio, F3
 Computer Science, I2
 Computing Center, K4
 Corwin, H3
 Cuyler, F4
 DeNunzio Pool, J7
 Dickinson, G3
 Dickinson Street
 Housing, D3
 Dillon Gym, F4
 Dinky (railroad station), E5
 Dod, F3
 Dodge–Osborn, G5
 East Pyne, F2
 Edwards, F3
 1879, H3
 Elementary Particles Labs, K7

Energy Research Lab, J2
 Engineering
 Quadrangle, J2
 Eno, G5
 Feinberg, G4
 Fine, H5
 Firestone Library, G2
 Fisher, H3
 FitzRandolph
 Observatory, K6
 Forbes College, D6
 48 University Place, E3
 Foulke, E3
 Frick, H3
 Gauss, F5
 Graduate College (residential
 and dining complex), B6
 Green, H2
 Guyot, H5
 Hamilton, E2
 Henry, E4
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 Hibben Apartments, G9
 Holder, E2
 Hoyt, H2
 Jadwin Gym, J7
 Jadwin Hall, H5
 Joline, E2
 Jones, G4
 Laughlin, E3
 Lenz Tennis Center, G7
 Little, E3
 Lockhart, E3
 Lourie–Love, G5
 Lowrie House, A2
 Maclean House, F2
 MacMillan, F6
 Madison, E2
 Magic Apartments, G9
 McCarter Theatre, E5
 McCormick, F3
 McCosh, G3
 McCosh Health Center, G4
 Mestres (Madison), E2
 Moffett, H5
 Mudd Library, I3
 Murray–Dodge, F3
 Nassau Hall, F2

New South, E5
 1912 Pavilion, H6
 Notestein Hall, H4
 185 Nassau Street, H2
 171 Broadmead, L5
 116 Prospect, K3
 Palmer, G4
 Palmer House, D1
 Palmer Stadium, I5
 Patton, F4
 Peyton, I5
 Princeton University
 Press, I2
 Prospect House and
 Gardens, G3
 Pyne, E4
 Robertson, H3
 Rock Magnetism Lab, G5
 School of Architecture, G3
 70 Washington Road, H4
 Spelman, E5
 Stanhope, F2
 Stevenson, J4
 Tennis Pavilion, F5
 Third World Center, J3
 Thomas, H5
 Train station (Dinky), E5
 University Store, E3
 Von Neumann, K3
 Walker, F4
 West College, F2
 Whig, F3
 Wilcox, G5
 Witherspoon, E3
 Woolworth, G3
 Wu, F5
 Wyman House, B6

Undergraduate Residential Colleges

Butler College
 Class of 1915, F5
 Class of 1922, G5
 Class of 1940, G5
 Class of 1941, G5
 Class of 1942, F5
 Lourie–Love, G5

Patton, F4
 Wu, F5

Forbes College
 D6

Mathey College
 Blair, E3
 Campbell, E2
 Hamilton, E2
 Joline, E2

Rockefeller College
 Blair, E3
 Holder, E2
 Madison, E2
 Witherspoon, E3

Wilson College
 Class of 1927–Clapp, G5
 Class of 1937, G4
 Class of 1938, G5
 Class of 1939, G5
 Dodge–Osborn, G5
 Feinberg, G4
 Gauss, F5
 Walker, F4
 Wilcox, G5

Graduate College

Residential and dining
 complex, B6
 Wyman House, B6

Eating Clubs

Campus Club, H3
 Cap and Gown Club, J4
 Charter Club, J4
 Cloister Club, J4
 Colonial Club, I3
 Cottage Club, I4
 Dial Lodge, I3
 Elm Club, I3
 Ivy Club, I4
 Quadrangle Club, I4
 Terrace Club, H4
 Tiger Inn, I3
 Tower Club, H4

Key Locations

Admissions (undergraduate), West College, F2
 Admissions (graduate), Nassau Hall, F2
 Alumni Council, Maclean House, F2
 Athletic event tickets, Jadwin Gym, J7
 Betts Auditorium, School of Architecture, G3
 Bookstore (University Store), E3
 Bus stop, Palmer Square, F1
 Career Services, Clio, F3
 Communications/Publications, Stanhope, F2
 Community and State Affairs, Nassau Hall, F2
Daily Princetonian, 48 University Place, E3
 Dean of Students, West College, F2
 Dean of the College, West College, F2
 Dean of the Faculty, Nassau Hall, F2
 Dean of the Graduate School, Nassau Hall, F2
 Dodds Auditorium, Robertson, H3
 Exhibits, see Art Museum; Firestone Library;
 Gest Oriental Library, Jones, G4; Mudd Library;
 and Natural History Museum, Guyot, H4
 Financial Aid (undergraduate), West College, F2
 Gardens, Prospect House, G3
 Gym, Dillon, F4; Jadwin, J7
 Health Services, McCosh Health Center, G4
 Housing, Macmillan, F6
 Human Resources (personnel), Clio, F3
 International Center, Murray–Dodge, F3
 Library, Firestone, G2; Archives, Mudd Library, I3
 Limousine service (to Newark airport),
 Palmer Square, F1
 Parking, visitor, lot 16, lot 10A;
 parking information, Stanhope, F2
 President, Nassau Hall, F2
Princeton Alumni Weekly, Princeton University Press, I2
Princeton Weekly Bulletin, Stanhope, F2
 Provost, Nassau Hall, F2
 Public Safety, Stanhope, F2
 Public telephones, Chancellor Green Center, F2
 Purchasing, Armory, I6
 Registrar, West College, F2
 Restrooms, Chancellor Green Center, F2
 Richardson Auditorium, Alexander Hall, E2
 Snack bar, Chancellor Green Center, F2
 Student center, Chancellor Green Center, F2
 Taplin Auditorium, Fine Hall, I5
 Taxi stand, Nassau Street, F1
 Theater, Intime, Murray–Dodge, F3; McCarter, E5
 Tours (Orange Key Guides), Maclean House, F2
 Treasurer, New South, E5
 Women's Center, Burr, H2
 Woodrow Wilson School, Robertson, H3

Emergency, accident, fire, call 258-3333



OFFICE OF THE VICE PRESIDENT
WASHINGTON

May 18, 1992

Professor Harvey S. Rosen
Co-Director
Center for Economic Policy Studies
Princeton University
Princeton, NJ 08544-1021

Dear Harvey:

Thank you for having me up to your august institution on Saturday to give the Administration's view on health care. Not many people seemed to buy our plan, but I am comforted that, after listening to everyone else, I am more convinced that we are on the right track.

One fellow in biotechnology venture capital came up to me after my remarks to complain about FDA. Things are getting so bad, his founders are starting to weigh options for getting out of the business. Their experiences with the FDA sound like something out of Kafka.

I am glad that you are so happy being back in the academy. I guess your strategy for dealing with a midlife crisis paid off -- and you don't even have any car payments for a Porsche!

I am enclosing receipts for \$25.00 for parking, train and cab expenses during my trip. I hope your Center can cover them.

I hope it is not another year before I see you again. Best wishes to Marsha and your family.

Sincerely,

Richard P. [Signature]



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CHANGE \$0.00
CASH PAID \$8.00

THANK YOU

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Fare Plane: \$7.00

Accom Charge: \$0.00

Total: \$7.00

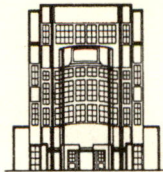
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May 14, 1992

The Honorable Richard Porter
Office of the Vice President
Room 200
Old Executive Office Building
Washington, DC 20501

Dear Dr. Porter:

Enclosed are your train tickets for your trip to Princeton on Saturday, May 16th. You will be met by A-1 Limousine and the driver will be displaying a sign with Gail Wilensky's name on it. You will be departing the train on the south side of the tracks. Please remain on that side--do not go through the tunnel to the north side. The driver will take you both directly to the Nassau Inn.

We have left your return ticket open. Should you decide to catch the 1:22 p.m. train from Trenton back to Washington with Gail Wilensky, a driver will pick you up at 12:45 p.m. at the Nassau Inn. If you decide to take a later train, we can easily arrange for a taxi to take you to the Trenton station.

If you have any further questions, please do not hesitate to call me.

Sincerely,

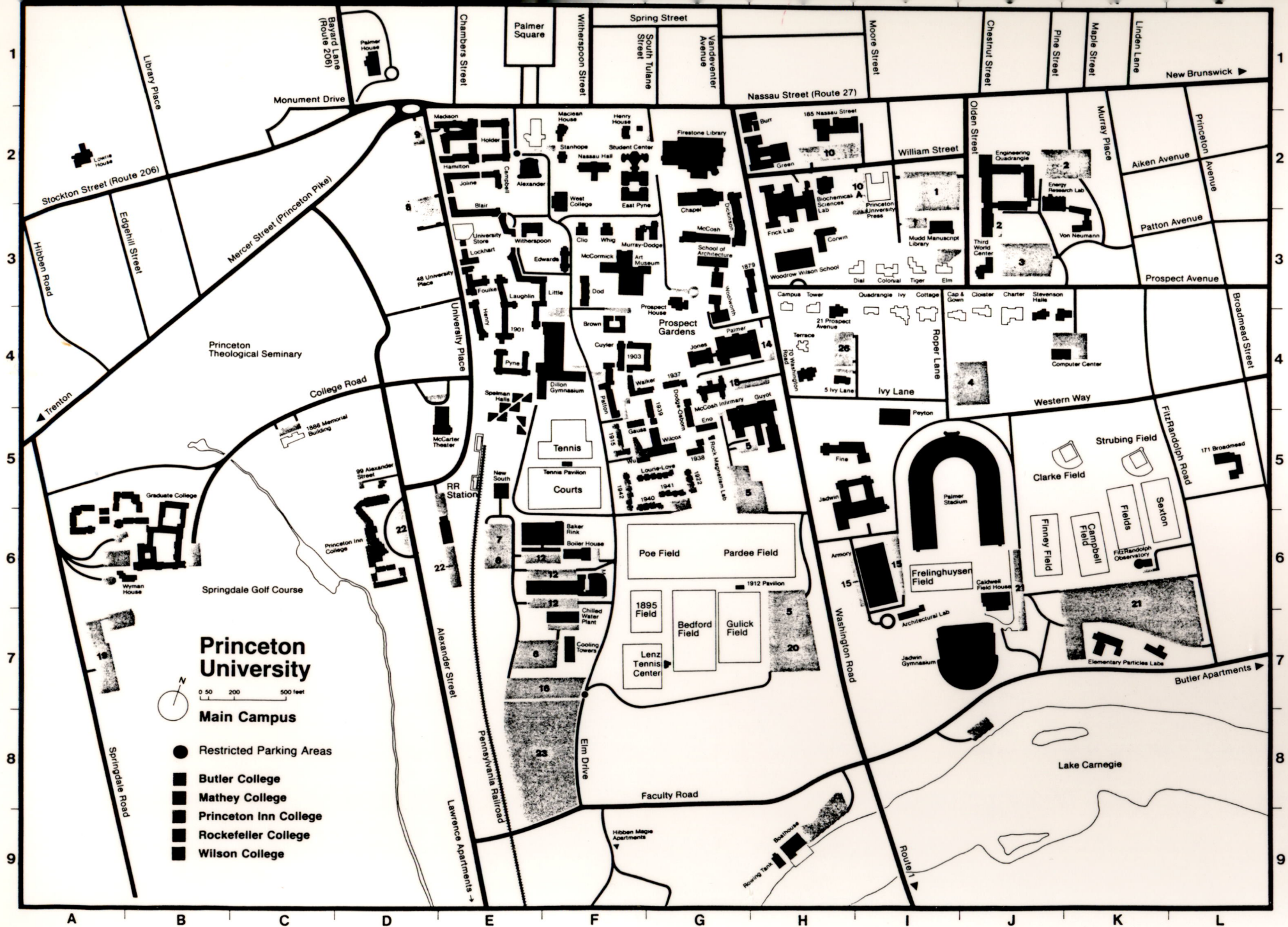
Phyllis J. Durepos
Secretary for CEPS

Encl.



Nassau Hall, Princeton University

Princeton



Program
CEPS Symposium
Princeton, May 15-16, 1992
Reforming America's Health Care System

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Center for Economic Policy Studies
Spring 1992 Symposium Participants

Reforming America's Health Care System

Henry Aaron
Alan & Madeline Blinder
Elizabeth & Thomas Bogan
Joseph Califano
Robert Clancy
Henry Farber
Joseph Fichera & Barbara Hughes-Boyer
James Gardner
Ed & Penny Glassmeyer
Stephen & Laura Goldfeld
Christine Grant & Michael Halpern
Robert & Barbara Hauptfuhrer
Samuel & Kathy Havens
John & Rosemary Hilley
Robert Hills
Joseph Hollander
Robert & Lynn Johnston
Alan & Lisa Krueger
James & Kate Litvack
Robin Lumsdaine
Walter & Alisa Maher
Burton Malkiel
Thomas & Tina March
Michael & Cecilia Mathews
Robert Matthews
James Mauzey
Ronald Miller
Robert & Susan Owens
Stephen & Amy Payne
Richard Porter
David Prescott
Uwe & May Reinhardt
Owen & Susan Roberts
Harvey Rosen & Marsha Novick
Richard Rosenberg
Steven & Sally Schroeder
Harold & Vivian Shapiro
Helen & Thomas Spiro
Paul & Sandra Starr
Richard Stuart
Warren Thaler
John Torkelsen
Gail Wilensky
Alan Willemsen
Barbara Wright
Paul Wythes

The Brookings Institution
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Princeton University
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Robert E. Clancy Associates
Princeton University
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Pfizer, Inc.
Oak Management Corporation
Princeton University
Merck Sharp & Dohme
Oryx Energy Company
Prudential Insurance Company
Chief of Staff for Senator Mitchell
Merck Sharp & Dohme
Merrill Lynch Private Client
Johnston Associates
Princeton University
Princeton University
Princeton University
Chrysler Corporation
Princeton University
DKM Properties Corporation
Bradford Ventures, Ltd.
Princeton University
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Bristol-Myers Squibb
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PA Consulting Group
Office of the Vice President of the U.S.
Gund Investment Corporation
Princeton University
Capital Formation Counselors
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Deputy Assistant to the President of the U.S.
F&G Re, Inc.
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This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

Statement of PAUL STARR
Princeton University
Hearings Before the Senate Finance Committee
May 6, 1992

Mr. Chairman, I appreciate the opportunity to join this morning's discussion. The uncontrolled growth in health costs and heightened insecurity about health insurance coverage in America today are not only an index of problems in our health care system. They are also an index of political and private-sector failure. We have had twenty years of well-intentioned efforts by government and employers to stem rising health costs within the existing system of insurance. Yet during the 1980s the health sector grew by an additional 1 percent of the GNP every forty months. The current dynamic of rising costs and eroding coverage threatens interests great and small, from mighty corporations that face staggering benefit costs to millions of uninsured working families unable to afford decent care for their children.

Our record looks especially dismal in international perspective. From 1945 to the early 1970s, health care costs increased everywhere in the West as a percentage of national income. In recent years, however, the health sector's relative growth in the U.S. has run far ahead of its growth elsewhere. In 1989 (the latest year for which international data are available), the leading nations in Europe and North America, as well as Japan, spent an average of 7.4 percent of national income on health care. America's 11.6 percent that year was by far the highest. Per capita, the United States spent 40 percent more on

health care than Canada, the second highest spender, and twice as much as major European nations, all with universal health insurance. And since 1989, the 11.6 percent of GNP we spent on health care has risen to more than 13 percent and seems headed for 17 percent or more by the end of the decade.

To most Americans lucky enough to be insured, the health insurance premiums taken out of their paychecks feel just like a tax--a tax whose annual increases their representatives in Congress and the White House have failed to control.

Imagine if over the past twenty years we had been able to keep health spending down to European--or even Canadian--levels: It would have been equivalent, in certain respects, to a vast tax cut, releasing private income for many other purposes.

Imagine the impact on government, too. The growing cost of health programs has crowded out other needs from public budgets at all levels. That crowding out is one reason for the disturbing shift in the composition of public expenditures over the past three decades from investment to consumption. This, too, does damage to the national interest.

As if the direct costs of health care were not enough, the U.S. economy is also suffering from indirect effects of our health care system. Take the following three examples:

1. According to recent surveys, three out of ten Americans say they or someone in their household have been unable to change jobs because of pre-existing health conditions that would be excluded from coverage by their new employer. When people are deprived of their freedom to change jobs, the economy is also deprived of the potentially greater

contributions they could make elsewhere.

2. While the insurance system locks some into jobs, it locks others into welfare. The principal alternative to welfare lies in low-paying jobs that rarely carry health benefits. Consequently, millions on welfare find that if they work, they cannot have secure access to health care. Welfare lock, like job lock, hurts productivity--and raises costs for government.

3. Conflicts over health benefits have become our leading cause of strikes, thereby also reducing productivity.

Job lock and welfare lock due to limited health coverage and strikes over health benefits are virtually unknown in the rest of the world's advanced economies. We inflict these distinctive economic harms upon ourselves. For the past two decades, we have told ourselves that America could not afford universal health coverage, even as other countries that guaranteed it both spent less for health care and avoided the damaging side-effects of our restricted and shrinking insurance system.

About ten years ago I wrote that the very meaning of national health insurance was changing from a way to increase health expenditures to a way to contain them--but that the country's leaders had failed to comprehend the change. I hope we are now at a turning point. The demand for health insurance security--and I stress the word "security" because the problem affects people with coverage as well as those without it--is a great, historic opportunity to rebuild our health care financing system and change its underlying incentives and organization.

And that is precisely what we need to do: There is a world

of difference between cost containment measures superimposed on the present system and cost containment that is embedded in the very structure of an alternative framework. The first has been, and will continue to be, not only ineffective, but the source of more bureaucracy, yet higher administrative costs, and increasing frustration and anger from providers and patients alike. Only when we face up to the full problem, and accept the need for systemic change, will we have any hope of remedy.

The ultimate objective of systemic reform, as I see it, is to reach deep inside the process of health care and change the way everyone concerned--doctors, patients, managers--thinks about the decisions they face. At the core of the problem are the "practice styles" of physicians, governing their everyday choices about when to order tests, hospitalization, surgery, prescriptions, further visits. Reform works best when it promotes a high-quality but conservative practice style--conservative in the sense of conserving resources. Today, all too often, doctors take uncertainty as grounds for treatment, even aggressive therapy with high risks. ("When in doubt, take it out," as one surgeon told me.) This kind of medical activism isn't just a threat to our economic interests in controlling health care costs; it's also a misfortune for patients. As countless studies show, health care expenditures end up producing, in aggregate, disappointingly little improvement in health. "More" in health care is not better, if by "better" we mean a healthier society; health care can cost less and count more in beneficial impact, as

shown by the record of other countries and by some health care organizations within the United States.

But how to create a more conservative practice style and, I might add, a more conservative style of health care management? A radical change in orientation will not spring up naturally, certainly not under the present system, which has richly rewarded the opposite practices. It will not do simply to promote better research on health care outcomes or changes in malpractice law, neither of which will offer sufficient motivation to revamp basic procedures. Nor will it suffice to create regulatory programs, in either the public or private sectors, which look for the exceptional cases of gross inefficiency, since the crux of the problem is accepted, everyday decision-making.

Two strategies, whose advocates are often strongly opposed to each other, offer what I believe to be the best chance of inducing a change in health care decision making and a reduction in the rate of growth of health expenditures. One strategy calls for budgetary control from the center; the other for competitive organizations generating decentralized cost-sensitivity. But despite this difference, the two approaches have certain similarities. Since everyone else emphasizes the contrasts, let me stress what the two strategies have in common.

Both strategies involve the creation of effective countervailing forces against the health sector's internal tendencies toward expansion. The first--the strategy of global budget limitation--concentrates purchasing power either in a

single payer or in a governmental body acting on behalf of payers to set comprehensive budgetary ceilings. We have long had a health care market dominated by sellers; this is an effort, in effect, to unify the buyers. The strategy seeks to impose hard budget constraints on the providers: lump-sum, global budgets for hospitals and fixed limits on total compensation available to physicians in a region. These budget constraints are intended to generate new decision-making environments, giving health care managers and professional peers incentives and leverage to bring about more conservative practices and to match health care resources to needs. Such is the logic of global budget limitation.

The competitive strategy, while more decentralized, also seeks to create greater countervailing pressure against the providers and budget-constrained decision-making environments where managers and peers have the incentive and leverage to induce more conservative practices. In this model, the countervailing forces are health maintenance organizations and other managed care plans, driven by competition to match their resources to the needs of their populations. The key step here is the replacement of fee-for-service with capitation payment, which generates the functional equivalent of a global budget--indeed, a more global budget, since capitation payment yields a comprehensive budget cap on all services, not just on hospitals.

To be sure, the first strategy relies more on "government," the latter more on the "market." But such generalities are highly

misleading, because the first strategy uses "government" in a different way from current regulation, and the second calls for a different "market" from the one that currently exists. Because global budgetary limitation relies on limits on total expenditures, it can dispense with much of the failed micro-regulation of the health care system. Indeed, as many observers of comparative health policy have noted, countries such as Germany and Canada that use such budget limits actually have less micro-regulation of health care than do we in the U.S.

The strategy of health care competition, on the other hand, requires constructing a different kind of market--a system that Alain Enthoven has aptly characterized as "managed" competition--to overcome the legacy of past policies and to control the tendencies toward market failure of a free market in health care. To get groups of providers to compete against each other requires, not deregulating the market, but actively reconstructing and managing it--for example, to combat opportunistic behavior by health plans that try to keep costs low only by enrolling healthy subscribers. The strategy of competition does not, therefore, dispense with public authority, although the role of the authority here is more to maintain "fair play" among competitors than to allocate resources or budgets.

Both strategies, finally, are carried out most effectively within the framework of universal health insurance programs. Either budget limitation or health care competition is a recipe for greater social inequity--and quite likely will not work in

practice--if we continue to exclude large parts of the population from coverage. No policy for controlling costs will be politically stable or widely attractive if it does not also answer the demand for health insurance security. Moreover, moving away from an insurance system based on employment is essential, not only because tying insurance to specific jobs inevitably produces gaps, discontinuities, and inequities in coverage, but because employers do not have the instruments--and generally do not have the knowledge or incentive--to exercise effective discipline over health care costs.

But which strategy to follow--overall budget limitation or health care competition?

The strategy of budget limitation has in its favor a proven record in other Western countries. That is precisely what some hold against it--the record is imperfect, and the other countries are different from ours. The strategy of health care competition is distinctively American, with a base in existing prepaid plans in the U.S. And that is precisely what some hold against it--the record here is imperfect, and it is hard to see how it will work throughout our country, as in rural areas where the population is too dispersed to support competing health plans.

But we may not need one answer for the entire country. Rather, we ought to consider universal insurance proposals that give the states, and even regions within them, a structure to adjust the mix of competition and budget limitation. For example, a promising proposal put forward in February by John Garamendi,

California's Insurance Commissioner, would create a "single sponsor" for health insurance in the various regions of the state. These "sponsors," which the Garamendi Plan calls Health Insurance Purchasing Corporations, would receive all employer and employee health insurance contributions and provide all citizens a menu of competing private health plans at varying prices (at least two of which in each region would be available at no extra cost). This is a unified system of health care competition on the model that Professor Enthoven has proposed. But, in some parts of the country, where the competitive model is either impractical or lacks support, the single sponsor could organize a single-payer system of insurance relying on global budgets for cost control.

Several national health insurance proposals before Congress, including S. 1446 (the "Health USA Act," introduced by Senator Kerrey) and S. 2513 (the "American Health Security Plan," introduced by Senator Daschle, Senator Wofford, and Senator Simon), provide both for national financing of universal health insurance and for the use of HMOs and other managed care plans by the states in carrying out their programs. These proposals would allow pluralism in the system, but they are not especially designed to foster competition. They also do not have any mechanism comparable to the Health Insurance Purchasing Corporations of the Garamendi Plan--an active sponsor concerned with managing competition among alternative private plans. One great advantage of such a mechanism is that revenue need not be channeled through the Federal Treasury; the local earmarking of

funds for health coverage may ease public suspicions that the required employer and employee contributions will disappear into a mysterious black hole in Washington! Moreover, the participation of private plans in the system will also ease fears of excessive concentration of power in government and reduce opposition from private industry, including large insurance companies.

With some modifications, the two Senate proposals I mentioned might provide a basis for giving the states several options in the design of comprehensive health reform. One such option would be to build choice of health plan into a framework of universal insurance that also includes various "upstream" controls on health care resources that should be regulated at the national level, such as training programs in the medical specialties.

This suggestion of combining the strategies of budgetary limitation and health plan competition is now heresy to the advocates of each, and perhaps puzzling to many others. But if we are going to replace our current system of "unsurance," as my colleague Uwe Reinhardt calls it, with genuine security of coverage, we need a new framework that generates an internal logic to conserve health care spending. And that framework, I believe, can use elements from both strategies I have described and provide for experiment and adaptation in line with the great diversity across the United States.

CEPS SPRING 1992 SYMPOSIUM

Reforming America's Health Care System

THE SPEAKERS

HENRY AARON, director of the Economic Studies program at the Brookings Institution, is the author or editor of eleven books and co-author or co-editor of ten others, including Serious and Unstable Condition - Financing America's Health Care (1991). He joined the staff of Brookings in 1968, and from 1967 through 1989 he was also on the faculty of the University of Maryland. He has served as Assistant Secretary for Planning and Evaluation at the Department of Health, Education and Welfare and chaired the 1979 Advisory Council on Social Security. He is currently Vice-President of the National Academy of Social Insurance and a member of the Players Association committee to study the economic condition of professional baseball. Aaron received his PhD in economics from Harvard University.

JOSEPH CALIFANO, former Secretary of Health, Education and Welfare, is an expert in health care delivery and cost containment. He is currently a senior partner with the law firm Dewey, Ballantine in New York. Mr. Califano has served in a number of positions within the U.S. military, including a three year stint in the Office of the Judge Advocate General in Washington while he was enlisted in the Navy. He also served as Special Assistant to the General Counsel of the Department of Defense, Special Assistant to the Secretary of the Army, General Counsel of the Army, Special Assistant to the Secretary of the Army for Civil Functions, and Special Assistant to the Secretary and Deputy Secretary of Defense. Mr. Califano received both the Distinguished Civilian Service Medal, the highest civilian award of the Army, and the Distinguished Service Medal of the Department of Defense. He was appointed Special Assistant to President Johnson in 1965, acting as LBJ's top domestic advisor. In 1977 he became Secretary of HEW. Over the years, Mr. Califano has been associated with several private law firms and has been admitted to practice before the Supreme Court of the U.S. Mr. Califano is a magna cum laude graduate of Harvard Law School and was editor of the Harvard Law Review.

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JOHN HILLEY is the Chief of Staff for Senate Majority Leader George J. Mitchell, where he is responsible for overseeing the staff of the Majority Leader and the Democratic Policy Committee. Prior to joining Senator Mitchell's staff, he has held a number of positions in government, including Staff Director and Assistant Director for Economics, Trade, and Finance for the Committee on the Budget of the U.S. Senate and Principal Analyst in the Fiscal Analysis Division of the Congressional Budget Office. He was also on the faculty of Lehigh University. Hilley received his B.A., M.A. and PhD in economics from Princeton University.

WALTER MAHER is the Director of Federal Relations for Chrysler Corporation and has held a variety of positions within Chrysler since joining the company in 1963. Mr. Maher is a member of the Physician Payment Review Commission, the Board of Directors of the Washington Business Group on Health and is actively involved with the National Leadership Coalition for Health Care Reform. He is also a member of the National Academy of Social Insurance and serves on the Labor and Employee Benefits Committee of the U.S. Chamber of Commerce and the Employee Benefits Committee of the National Association of Manufacturers. Mr. Maher received his law degree from Georgetown University in 1963.

RICHARD PORTER was appointed Counselor to the Vice President in January, 1992, and has responsibilities in the areas of politics and policy development. Prior to this appointment, he served as Special Assistant to the President and Executive Secretary to the Domestic Policy Council. He has also served as Deputy Assistant Secretary for Policy Review and Analysis at the Department of the Treasury, as an analyst and the chief writer on the domestic policy staff of Bush/Quayle '88, as a law clerk to Judge Richard A. Posner on the U.S. Court of Appeals, and as a lawyer/economist at Lexecon, Inc., a law and economics consulting firm. Mr. Porter began his career at IBM as a Systems Engineer and a Marketing Representative. He is a graduate of Middlebury College and received his law degree from the University of Chicago Law School, where he was an Olin Fellow and a member of the Law Review.

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STEVEN SCHROEDER is President of the Robert Wood Johnson Foundation in Princeton, New Jersey, the nation's largest health care philanthropy. Dr. Schroeder received his B.A. degree from Stanford University and M.D. degree from Harvard Medical School. He was trained in internal medicine, epidemiology and public health. Dr. Schroeder has held faculty appointments at Harvard, George Washington University and the University of California at San Francisco. At both GW and UCSF he was the founding medical director of a university-sponsored health maintenance organization. He has over 120 publications in the fields of clinical medicine, health care organization and financing, manpower, quality of care, and preventive medicine. Dr. Schroeder has been a member of a number of health care organizations, including the American College of Physicians, the American Public Health Association, the Institute of Medicine of the National Academy of Sciences and the Society of General Internal Medicine (President, 1985-86).

HAROLD SHAPIRO is Princeton University's 18th president and holds a faculty appointment as a Professor of Economics and Public Affairs. President Shapiro came to Princeton from the University of Michigan where he served on the faculty for twenty-four years as professor of economics and public policy and as president from 1980-1988. He is a member of the Conference Board Inc. and The Bretton Woods Committee, is Chief Economic Advisor for Junior Achievement, Inc., and is a trustee of the Alfred P. Sloan Foundation, the Universities Research Association, the Consortium on Financing Higher Education, and Interlochen Center for the Arts. He also serves as a director of the Dow Chemical Company and the National Bureau of Economic Research. President Shapiro is a member of President Bush's newly established Council of Advisors on Science and Technology and serves as Chairman of the Institute of Medicine's Committee on Employer-Based Health Benefits. He received a PhD in economics from Princeton University in 1964.

PAUL STARR is a Professor of sociology at Princeton University and the author of The Social Transformation of American Medicine, winner of the Pulitzer Prize for Nonfiction, the Bancroft Prize in American History, the C. Wright Mills Award, and the James Hamilton Prize of the American College of Health Care Executives. His new book, due to be published late this year, is tentatively titled The Logic of Health Reform. Professor Starr is also the co-founder and co-editor of The American Prospect, a journal of public policy and liberal opinion. In addition to health care, he writes on a variety of topics, including American society and politics, the communications media, privatization, and the liberal state.

GAIL WILENSKY currently serves as Deputy Assistant to the President for Policy Development. Her primary focus in this capacity is advising the President on health and welfare issues. Prior to joining the White House staff, she was administrator of the Health Care Financing Administration, where she directed the Medicare and Medicaid programs. Dr. Wilensky came to HCFA from Project Hope, where she was Vice President of Health Affairs. She has served on the faculties of the University of Michigan and George Washington University, and held a senior appointment at the Urban Institute. She is a member of the Institute of Medicine of the National Academy of Sciences and was a member of the Physician Payment Review Commission and the Health Advisory Committee of the General Accounting Office. Dr. Wilensky earned a PhD in economics from the University of Michigan.

AN *ALL-AMERICAN* HEALTH-REFORM PROPOSAL

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If Americans are asked what they think of their *health system*, they now typically give it a very low rating. If, on the other hand, Americans are asked what they think of the quality of the *health care* available in their own community, they usually give that care a very high rating. The difference between *health system* and *health care*, of course, is the manner in which a nation *finances* that care. It is this nation's unwieldy, wasteful, unreliable, sometimes inhumane and increasingly moribund *health insurance* system that gives the American *health system* its black eye in national and international opinion surveys.

The design of a superior health insurance system must begin with a specification of the *ethical precepts* that system is to obey. For example, one might dictate that the system should not exclude families from insurance coverage--that it should be *universal*. Second, one might specify that the system should decouple the individual household's premiums from the health status of its members. One might even go so far as to say that the household's premium should be based strictly on the household's *ability to pay*, as is the case under West Germany's statutory health insurance system.

The design of a superior health insurance system also should incorporate certain technical features. For example, one might specify *ex ante* that health-insurance coverage be *portable* between jobs and from jobs into unemployment or retirement. Furthermore, one might require that the system should be *administratively simple* from the perspective of both the insured and the providers of health care. Next, one might demand that the system should concentrate sufficient market power in the hands of patients and third-party payers to facilitate *cost control*. Finally, one might impose the design spec that the system should not forcibly impose on business tasks that are properly the government's, namely, to act as a tax collector for health insurance¹.

¹ A moment's thought should make it clear that "business" never pays any tax. It merely pays it in the first instance and then recoups it from either owners, customers or employees. In that sense, a government mandate upon business to provide employees health insurance merely appoints business firms as intermediary tax collectors.

The current American health-insurance system meets none of these ethical precepts or design specs. First, the system eclipses some 35 million Americans from coverage altogether, leaves another 20 million or so underinsured and, in many instances, condemns households with severely sick members to deep poverty. Second, the system ties the insurance protection of entire American families to particular jobs that are easily lost in the turbulent climate of the global market economy. Third, ours unquestionably is the administratively most cumbersome health insurance system in the world. It absorbs a higher fraction of health spending in administration than does any other health system in the industrialized world. Finally, by splintering the demand side of the health sector into literally thousands of small third-party payers, each lacking significant market clout vis a vis providers, the system has amply demonstrated its inability to control the annual growth of health spending.

The problem with our current health insurance system, of course, is not that the people working within it are either malicious or slovenly; they work hard and mean well. Rather, the system is so poorly configured that it literally brings out the worst in a basically decent group of citizens. A productive reform of the system must be one that channels the efforts of these hard-working people towards socially more desirable ends.

One approach that might achieve this goal would be the following private-public sector partnership, designed to enlist strengths of both sectors, and rooted in the social ethic apparently preferred by Americans. Because the media insist that every proposal have a catchy name, I dub it the *All-American Deal*², to signify that it is not just some foreign import.

Under the approach proposed here, employers would be left free to offer their employees health insurance as part of a total compensation package freely negotiated in the labor market. Many firms probably would find it a good come-on in that competitive market. But employers would not be *forced* to make that offering, a policy that would most likely lead them to shift back most of the premiums to their workers in the form of lower cash wages in any event. Instead, every American family would be mandated to carry basic, comprehensive health-insurance coverage and that coverage would be made available to all families at premiums they could afford. Here's a thumbnail sketch of how this program

² My most preferred label is *The All-American, Public-Private, Judeo-Christian Health-Care Partnership Plan*.

might work.

On the 1040 tax forms, there would be two special lines pertaining to health insurance. On line 31a, for example, the taxpayer would be asked to enter X% of adjustable gross income as a premium for the *Fail-Safe* health-insurance package automatically bestowed upon that taxpayer's household, unless that household attaches evidence of a private policy at least as comprehensive as the *Fail Safe* policy. The premium rate "X" would increase with income. It would be close to zero for very low-income households and might reach 13 to 15% for high-income households. If written evidence of an adequate private policy were attached, the household would be excused from the premium tax on line 31a, but would be asked to pay, on line 31b, an small, progressive, earmarked *indigent-care* tax (perhaps an average 1% or so of taxable income). These funds would be needed to supplement the modest premiums collected from low-income families. Additional funds might be extracted from earmarked health taxes on alcohol, tobacco and gasoline, products known to contribute directly to the nation's health bill. Ideally, if it were politically feasible, the pool could be fed also from added taxes yielded by limits on the tax-exclusion of employer-provided health insurance premiums. If the entire employer-paid premium were added to the employees taxable income, then close to \$ 50 billion of additional federal income taxes would be yielded by the present pattern of private insurance (and another \$20 billion or so in additional FICA taxes).

The mechanisms described above deal only with one facet of a health-insurance system, namely, the extraction of funds from individual households (who are always the ultimate payers in a health system) into an insurance fund. Let us call it the *financing/insurance* facet. There remains the second facet, namely, the funneling of these funds to the providers of health care. This facet might be labelled *procurement/cost control*.

Now, a given *financing/insurance* mechanism can be coupled with a great variety of distinct *procurement/cost control* systems--an important point often lost in the debate on health policy when, for example, "managed care" is styled as a complete health-insurance program³. "Managed care" is not that; it is merely a particular *procurement/cost control* device.

To illustrate, the Federal government could use its *Fail-Safe* fund simply to enroll all

³ *The New York Times* does this in its editorials with alarming regularity.

Americans who are not privately insured in the federal Medicare program. This would be the single-payer option proposed by some health reformers.

Alternatively, however, the federal government could distribute the funds to the states in the form of capitation payments that are adjusted for age, sex and unavoidable regional cost variations. A fully operational mechanism for such capitation payments already exists for the Medicare program. The individual states could then use these capitations (possibly supplemented with state funds) either to enroll uninsured families in a public, state-run program, or to let such families choose one from a roster of private "managed care" systems, an approach otherwise known as "managed competition."

If the latter approach were taken, it would come to resemble the Administration's plan, although it would be much, much simpler, it would be fully universal, and it would include explicit financing, the *sine qua non* of any serious health reform proposal.

Would this insurance plan eventually establish a two-tiered health-care system? It would. But Americans evidently favor this two-tiered approach in other important human-services sectors, notably in education and in jurisprudence. Even otherwise egalitarian Liberal thinkers often rely on the upper-tier private segments of these two sectors for their own families, if they have the means to do so. Furthermore, the two-tiered insurance system proposed here would be a far cry better than the multiple-tier system now in place that literally offers "nothing" as its lowest tier. One should not evaluate proposed health-care reforms by ideal standards unlikely ever to be reached in practice. As Senator Moynihan has so aptly put it, in matters of social policy one should must not let the [hypothetical] best become the enemy of the [achievable] good.

PROVIDING ACCESS TO HEALTH CARE AND CONTROLLING COSTS:

The Universal Dilemma

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The human condition surrounding the delivery of health care is everywhere on the globe the same:

The providers of health care seek to give their patients the maximum feasible degree of physical relief, but overall (if not for every patient they treat) they also seek a goodly slice of the GNP, in the form of money-vouchers, as a reward for their efforts.

Patients seek from the providers of care the maximum feasible degree of physical relief, but collectively (if not in each and every case) they also seek to minimize the amount of GNP that must be granted the providers as a reward for their efforts.

In other words, while there typically is a meeting of the minds between patients and providers on the *clinical* side of the health-care transaction, there very often is conflict on the *economic front*. It has always been so, since time immemorial, and it will always be so, from here to kingdom come. It is part of the human condition.

Health insurance does not lessen this perennial economic conflict; it merely transfers it from the patient's bedside to the desk of some private or public bureaucrat charged with guarding a collective insurance treasury.

But health insurance does realign the parties to the economic fray. Because insurance shields patients from the cost of their medical treatments at point of service, it tends to move them squarely into the providers' corner when they are sick. Usually, in that corner, they rail against the heartless bureaucrats who refuse to surrender the key to the collective insurance treasuries they are there to guard. When patients are healthy and faced with mounting taxes or insurance premiums, on the other hand, they are typically found in the bureaucrats' corner. In that corner they rail against the voracious financial appetite of health-care providers.

Such is the intellectual purview from which the proverbial man and woman in the street beholds the health-care sector. That, too, is part of the human condition.

In this essay, we shall explore how different nations approach the universal twin problems of modern health care: the provision of access to health care on equitable terms and the control of the cost of health care. It will be seen that there is a rich variety of alternative approaches to this twin problem; but there is no single *ideal* solution.

I. CONTROLLING THE TRANSFER OF GNP TO PROVIDERS

Society can control the total annual transfer of GNP to the providers of health care through the demand side of the health care market, through its supply side, or through both. Nations differ substantially in the mix of approaches used to this end. Their choice of cost-control policies hinges crucially on the social role that is ascribed to health care. The two extremes of the spectrum of views one may have on this issue are:

1. Health care is essentially a *private consumption good* whose financing is the responsibility of its individual recipient.
2. Health care is a *social good* that should be collectively financed and available to all citizens who need health care, regardless of the individual recipient's ability to pay for that care.

Canadians and Europeans have long ago reached a broad social consensus that health care is a *social good*. Although their health systems exhibit distinct, national idiosyncracies, these systems share in common their obedience to that over-arching ethical precept.

Americans have never been able to reach a similarly broad, political consensus on just where on the ideological spectrum defined by these two extreme views they would like their health-care system to sit. Instead, American health policy has meandered back and forth between the two views, in step with the ideological temper of the time. During the 1960s and 1970s, the American health system moved towards the *social-good* end of the spectrum. During the 1980s, on the other hand, a concerted effort was made to move the system in the opposite direction. This meandering between distinct ethical precepts has produced contradictions between professed principles and manifest practice that amuse the foreigner and that confuse and frustrate even the initiated at home. For example, at this time in the nation's history, poor, uninsured Americans often find it difficult to gain access to health-care resources of which the nation has too many.

Table 1 presents a menu of alternative approaches to financing and organizing health care. That display distinguishes explicitly between the ownership of the *health insurance* mechanism and the *production* of health care. Almost all health-care systems in the world can be fit into this grid.

[Table 1]

The health system of the United Kingdom and of Sweden, for example, occupy primarily Box A in Table 1, although private medical practices in the United Kingdom

Table 1

ALTERNATIVE MIXES OF HEALTH-INSURANCE AND HEALTH CARE DELIVERY

PRODUCTION AND DELIVERY	COLLECTIVIZED (SOCIALIZED) FINANCING OF HEALTH CARE.			DIRECT FINANCING
	Government Financed Insurance	Private Health Insurance ^a		Out of Pocket by Patients at point of Service
		within a statutory framework	within an unregulated market	
Purely Government Owned	A	D	G	J
Private Not-for- Profit Entities	B	E	H	K
Private For- Profit Entities	C	F	I	L

The Canadian
Health
System

The West
German
Health System

The private portion of the
American System

^a Note: Technically, whenever the receipt of health care is paid for by a third party rather than by the recipient at point of service, it is financed out of a collective pool and is thus "socialized" financing. In this sense, private health insurance is just as much "collectivist" or "socialized" as is government-provided health insurance. Both forms of financing destroy the normal workings of a market, because both eliminate the individual benefit-cost calculus that is the sine-qua-non of a proper market.

occupy box C. One may think of Box A as *socialized medicine* in its purest sense, because the *production* of health care is substantially owned by the government. Clearly, the health system of the U.S. Department of Veterans Affairs resides in Box A as well, as does the bulk of the health-care system for the U.S. armed forces. It has been said that President Eisenhower, staunch opponent to *socialized medicine*, actually spent the bulk of his adult life in just such a system.

The Canadian health system occupies primarily cells A, B and C, as do the bulk of the American Medicare and Medicaid programs. These systems represent *public health insurance*, but not *socialized medicine*.

West Germany's health system is best described by cells D, E and F. It also does not represent *socialized medicine*. As noted above, the American health system is likely to slide towards that sort of arrangement before too long. At this time, the bulk of that system continues to reside in boxes G to L.

A. The Approaches used in Canada and Europe

As noted, Canadians and Europeans typically view health care as a *social good*. In these countries it is anathema to link an individual household's contribution to the financing of health care to the health status of that household's members. Health care in these countries is collectively financed, with taxes or premiums based on the individual household's ability to pay. Only a small well-to-do minority--so far less than 10 percent of the population--tends to opt out of collective, social insurance in favor of privately insured or privately financed health care. Over 90 percent of the population in these countries typically share in common one level of quality and amenities in health care.

Control over health-care costs in these countries is exercised primarily by controlling the capacity of the *supply side*. The chief instrument for this purpose is formal regional health planning. Planning enables policymakers to limit the number of hospital beds, big-ticket technology such as CAT-Scanners or Lithotripters, and, sometimes, even the number of physicians issued billing numbers under these nation's health-insurance systems.

Regulatory limits on the capacity of the health system inevitably create monopolies on the supply side. To make sure that these artificially created monopolies do not exploit their economic power, these countries always couple health planning with stiff price- and budgetary controls. Where the intent of price controls has been thwarted through rapid increases in the volume of health services rendered, for example, these countries eventually impose strictly limited global budgets on hospitals and doctors. Thus, Canada has long compensated its hospitals through pre-set global budgets. Similarly, West Germany now operates strict, state-wide expenditure caps for all physicians practicing within a state under

the nation's Statutory Health Insurance system. The United Kingdom and the Nordic countries budget virtually their entire health systems.

Figure 1 illustrates this three-pronged approach to health-care cost-control: (1) limits on physical capacity, (2) limits on fees and prices and (3) limits on overall expenditures.

[Figure 1]

To effect their price- and budget controls, Canada and the European countries tend to structure their health-insurance systems so that money flows from third-party payers to the providers of care only through one or a few large money-pipes whose money-throughput is then controlled through formal negotiations between regional or national associations of third-party payers and associations of providers. As already noted, usually the negotiated prices in these countries are binding upon providers, who may not bill patients extra charges above these prices. Although France permits extra billing within limits, most of these countries see unrestrained extra billing as a violation of the spirit of health insurance.

The extreme version of this payment policy is illustrated in the bottom panel of Figure 2. It is the approach used in the typical Canadian province, where the provincial government administers both the hospital-insurance and the physician-service insurance plans.

[Figure 2]

Remarkably, and in sharp contrast to the United States, Canada and Europe typically do not look to the individual patient as an agent of cost control: usually there is not a significant flow of money from patient to provider at the time health services are received. Instead, most of these countries provide patients with comprehensive, universal, *first-dollar* coverage for a wide range of services, typically including drugs (although Canada covers these only for the poor). France does have some co-payments at point of service, but usually not for serious illnesses. Furthermore, many French patients have supplemental private insurance to cover any co-payments.

One should not assume that Canada and the European nations eclipse patients from the chore of cost control because these nations' health-policy analysts and policymakers lack the savvy of their American colleagues who, in their debates on health policy, tend to style patients as "consumers" who are expected to shop around for cost-effective health care. Rather, one suspects that Canadians and Europeans are inclined to perceive patients as, for the most part, "sick persons" who should be treated thus. Table 1 suggest why that perception may be a valid one.

FIGURE 1

THE CANADIAN/EUROPEAN APPROACH

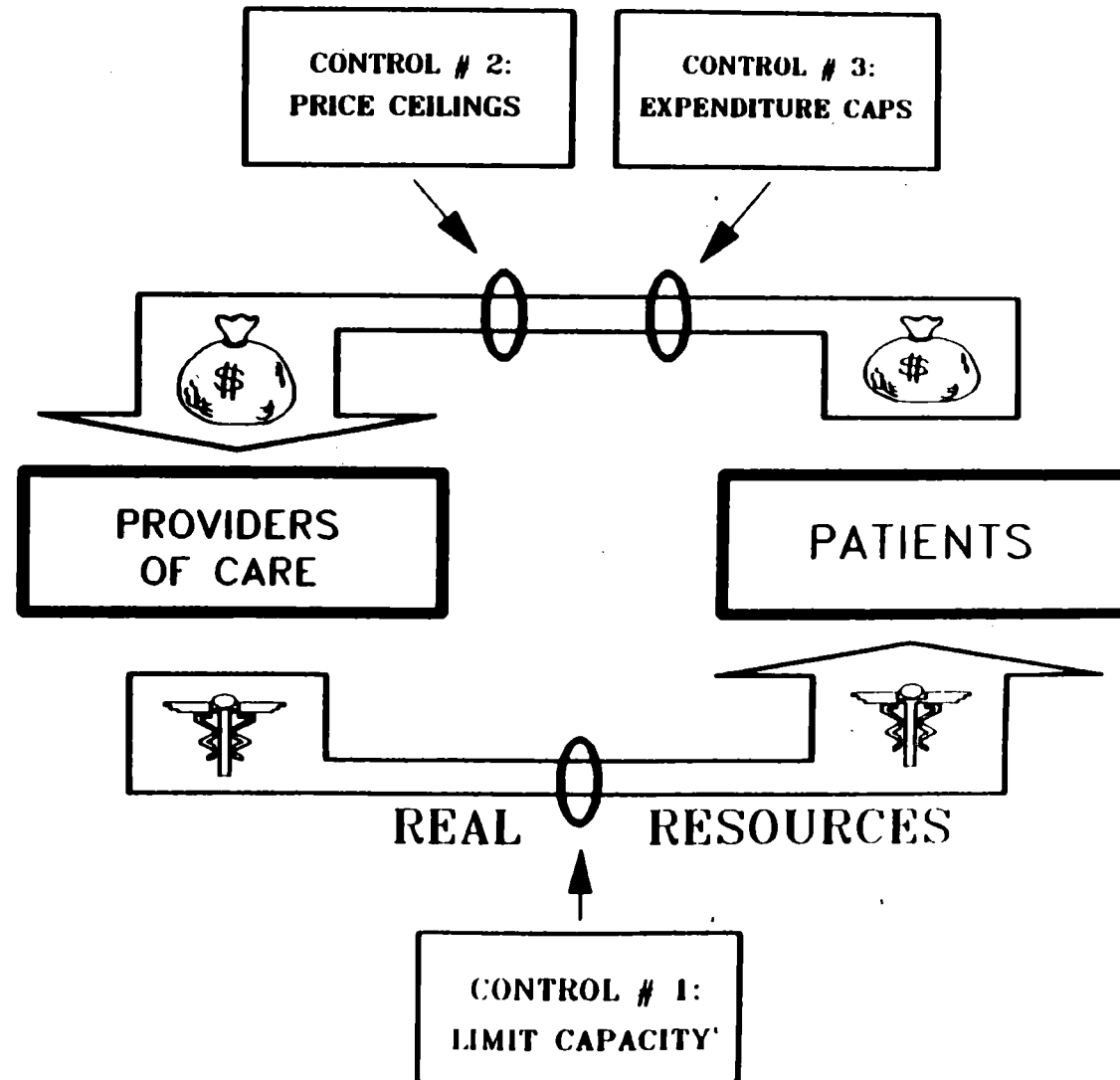
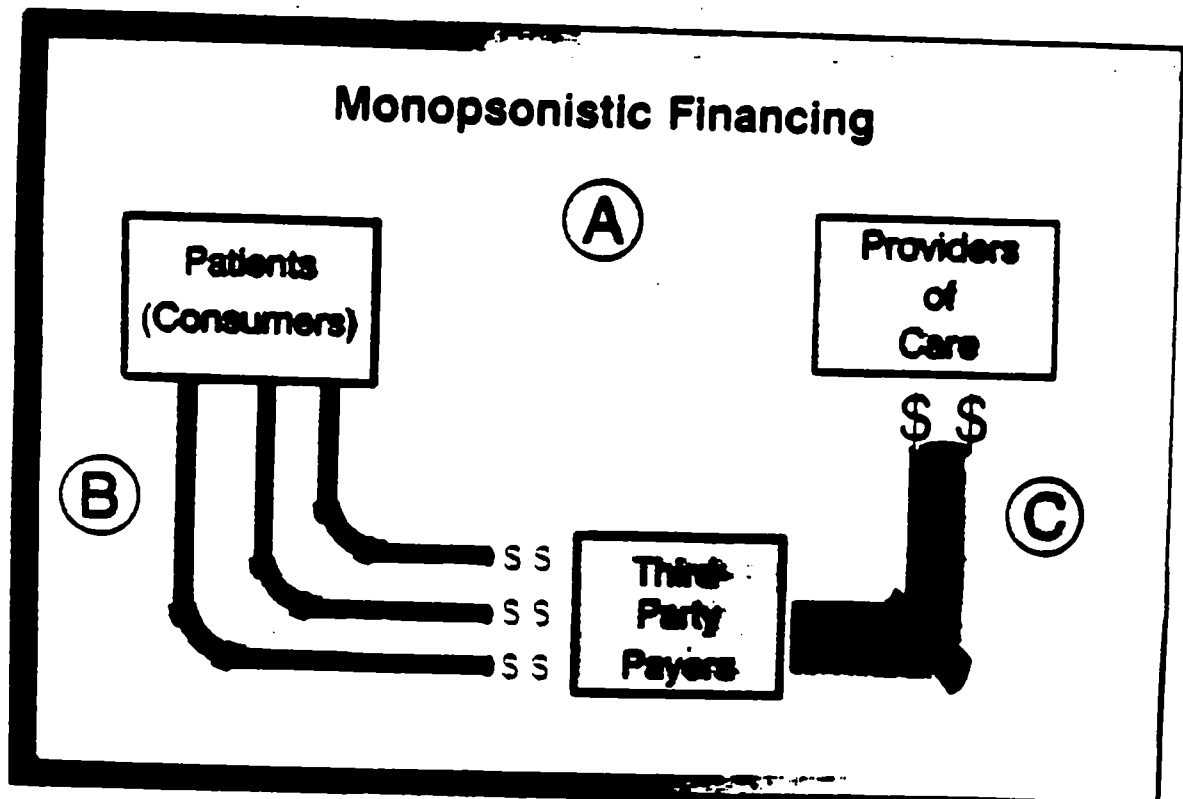
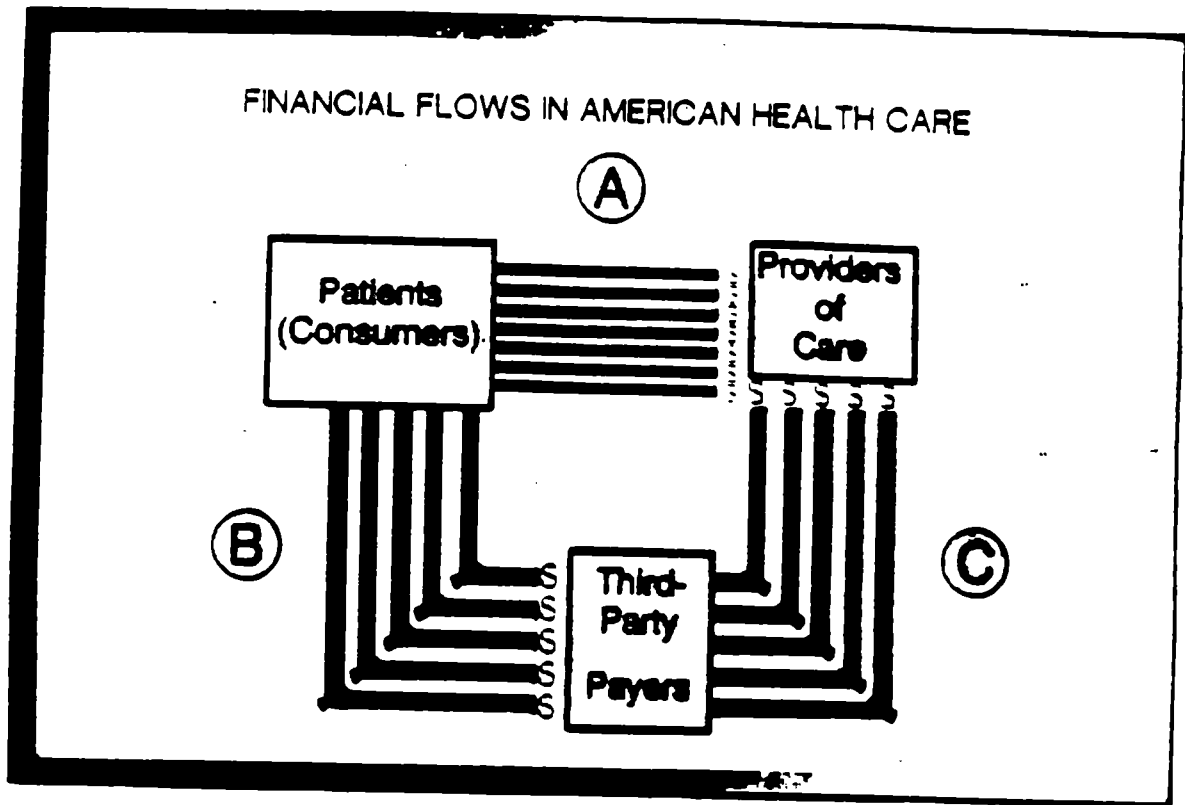


FIGURE 2

ALTERNATIVE FINANCIAL ARRANGEMENTS BETWEEN PATIENTS, PROVIDERS AND THIRD-PARTY PAYERS



[Table 2]

As Table 2 illustrates, the distribution of health expenditures across a population tends to be highly skewed. In the United States, for example, only about 5% of the population accounts for as much as half of all national health expenditures in any given year, and 10% account for as much as 70% to 80% of all health spending (see Table 1). The distribution of health expenditures in other countries is apt to trace out a similar pattern.

One must wonder whether the few individuals who account for the bulk of health-care expenditures in any given year actually can act as regular "consumers" who shop around for cost-effective health care. Although cost-sharing by patients can be shown to have some constraining effect on utilization for mild to semi-serious illness, it is unlikely to play a major role in the serious cases that appear to account for the bulk of national health care expenditures.

Where price and ability to pay cannot ration health care, something else must. Usually, in Canada and in Europe, that non-price rationing device is a queue for elective medical procedures. At the extreme, some high-tech medical interventions--e.g., renal dialysis or certain organ transplantations--are simply unavailable to particular patients, if the likely benefits from the intervention are judged by the attending physician to be low.

More generally, high-tech innovations are introduced rather cautiously in these nations, and only after intensive benefit-cost analysis. At any given point in time, these nations' health systems are therefore likely to lag behind the United States in the degree to which a new medical technology has been adopted.

Finally, the tight control on overall outlays for health care tends to preclude the often luxurious settings in which health-care is dispensed to well-insured patients in the United States. Atriums and gourmet dining in hospitals, or physician office with plush, deep carpets are not common in Canada or in Europe.

B. The Entrepreneurial, American Approach

Americans have traditionally looked askance at regulation. To be sure, some regulatory controls of the supply-side of health care have been attempted at various times in a number of States (through so-called Certificate-of-Need laws) and there have also occasional flirtations with price controls (e.g., under Richard Nixon's Presidency, or in States that regulate hospital rates).

TABLE 2
DISTRIBUTION OF HEALTH EXPENDITURES OVER THE
U.S. POPULATION
(Selected Years)

PERCENT OF U.S. POPULATION	PERCENTAGE OF TOTAL HEALTH EXPENDITURES ACCOUNTED FOR BY THAT PERCENTILE OF THE U.S. POPULATION		
	1970	1977	1980
Top 1 percent	26%	27%	29%
Top 2 percent	35%	38%	39%
Top 5 percent	50%	55%	55%
Top 10 percent	66%	70%	70%
Top 30 percent	88%	90%	90%
Top 50 percent	96%	97%	96%

SOURCE: Berk, Monheit and Hagan (1988), Exhibit 1, p. 50.

For the most part, however, Americans have always viewed the supply-side of their health sector as an open economic frontier in which any and all profit-seeking entrepreneurs may seek their economic fortunes. Indeed, traditionally Americans have seen the very openness of their health system to profit-seeking entrepreneurship as the key driving force that has made the American health system, in their own eyes, "the very best health-care system in the world."

American physicians, for example, have always prided themselves on their status as staunch "free-enterprisers" and they have vigorously, although not entirely successfully, defended that status against inroads by third-party payers. Furthermore, as historian Rosemary Stevens has shown convincingly in her recent *IN SICKNESS AND IN WEALTH: A History of the American Hospital in the Twentieth Century* (1988), even the nation's so-called not-for-profit hospitals have typically run their enterprises very much on business lines, and they normally have booked profits, although they do not distribute them to any outside owners.

In contrast to Canada and Europe, who tightly control the supply-side of their health sector, Americans have generally¹ freely opened theirs to the seekers of fortune in the belief that the transfer of GNP the providers of care can extract from the rest of society can easily be controlled through the demand side of the sector--primarily by forcing patients to behave like regular consumers. Figure 3 illustrates that so-called "market approach" to health care in its purest form.

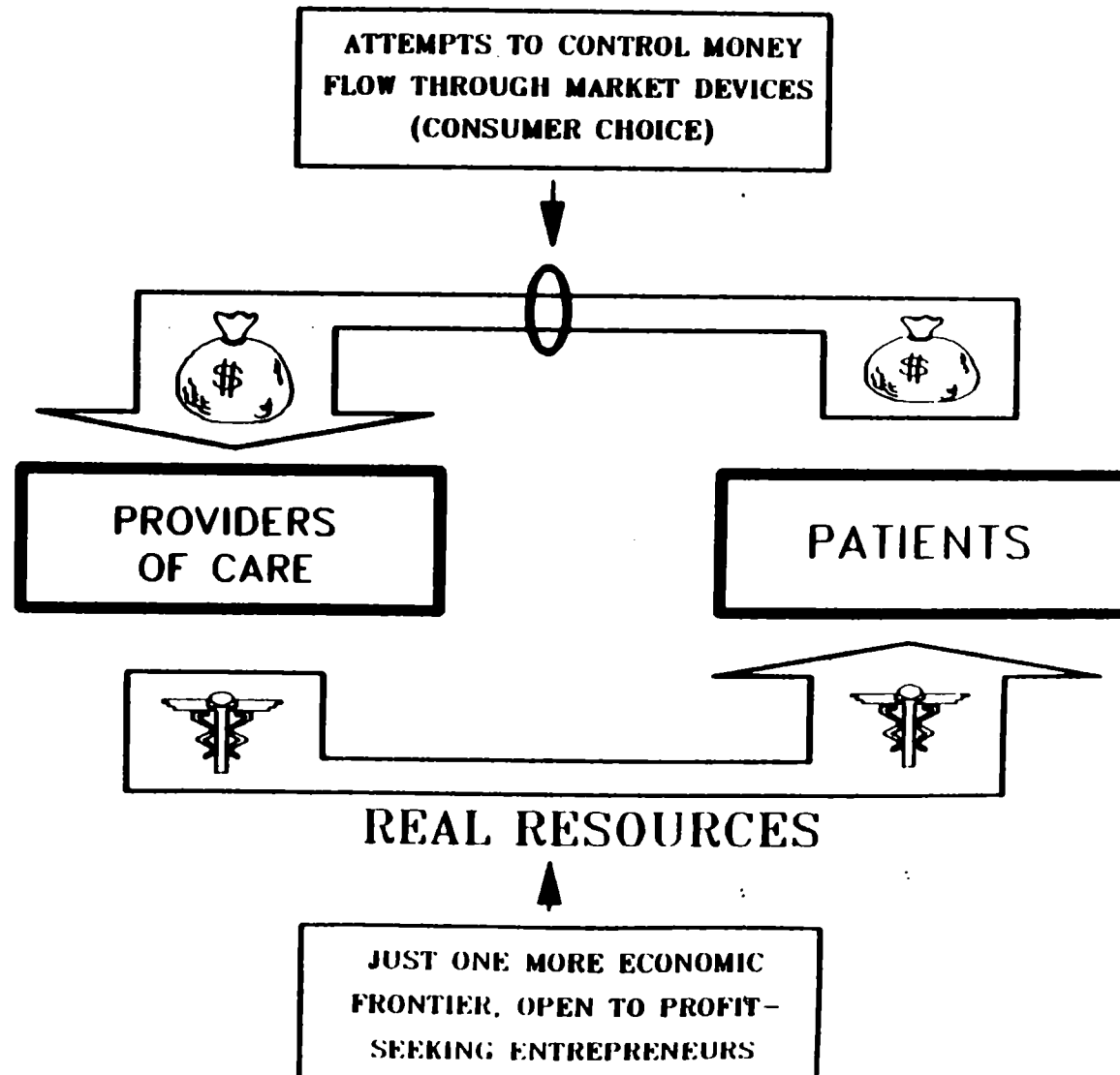
[Figure 3]

The traditional instrument of demand-side cost-control in the United States has been cost-sharing by patients. As is shown in Table 3, *on average*, American patients are not nearly as well insured as is sometimes supposed--not even in the heyday of the Great Society--although there is a wide dispersion around this average. Some Americans have no health insurance at all, others have very shallow insurance, and some receive from their employers relative generous coverage that approximates the comprehensive, first-dollar coverage available to Canadians and Europeans. Typical among the latter insured are unionized workers in the Northern rust belt.

¹ As already noted, some States in the U.S. do control certain segments of their health sector through formal planning--for example, through so-called Certificates-of-Need for hospital beds or hospital-based high-tech equipment. In fact, however, these strictures have generally been of limited effectiveness. Where hospitals have been prohibited from acquiring certain high-tech equipment, for example, physicians have nevertheless been able to acquire it and to operate it in close proximity to the hospital.

FIGURE 3

THE AMERICAN HEALTH-CARE SECTOR



[Table 3]

Even the relatively high degree of cost sharing by American patients, however, has not appeared to be able to constrain the growth of national health-care expenditures. As Table 2 above suggests, perhaps that particular donkey is just too weak to carry much of a cost-containment load. For that reason, additional forms of demand-side controls have been deployed in recent years, to wit, (1) ex post utilization control, (2) prospective and concurrent utilization review by third party payers (otherwise known as "managed care"), and (3) the so-called Preferred Provider Organizations (PPOs). These PPOs are networks of fee-for-service providers who have agreed to grant large third-party payers price discounts in return for insurance contracts that steer the insured toward these "preferred" providers through specially tailored forms of cost sharing.

A uniquely American form of cost-control, aimed more at the supply-side of the health-care market, is the Health Maintenance Organization (HMO). Basically, the HMO is an insurance contract under which a network of providers is pre-paid an annual lump-sum capitation per insured, in return for the obligation to furnish the insured all medically necessary care during the contract period. The contract is designed to make providers hold to the medically necessary minimum their use of resources in treating patients. Usually, the HMO contract leads to lower rates of hospitalization, other things being equal, and to relatively lower average per-capita health costs. Their drawback, in the eyes of patients, is that they limit choice among providers, and that they may under-serve patients.

II. THE ECONOMIC FOOTPRINTS OF THESE APPROACHES

It is generally agreed, both here and abroad, that the American, entrepreneurial approach to health care has begotten one of the most luxurious, dynamic, clinically and organizationally innovative, and technically sophisticated health systems in the world. At its best, that system has few rivals anywhere, although many health systems abroad also do have facets of genuine excellence.

A. The Cost of Health Care

Unfortunately, but perfectly predictably, the open-ended American health system is plagued by perennial excess capacity in most parts of the country, and by large and rapidly growing costs. With the exception of New York City--where capacity has been tightly controlled through health planning--the average hospital occupancy-ratio in the United

TABLE 3

DIRECT OUT OF POCKET EXPENDITURES FOR HEALTH CARE
UNITED STATES, 1977 AND 1987

TYPE OF SERVICE	PERCENTAGE PAID OUT OF POCKET	
	1977	1987
Physician Services	34%	26%
Ambulatory Physician Care only ^a	59%	N.A.
Hospital Services	8%	10%
Dental Care	73%	61%
Drugs and Medical Sundries	83%	75%
Nursing Home Care	43%	49%
TOTAL PERSONAL HEALTH CARE	31%	28%

^a Data from the National Medical Expenditure Survey (NMCES), 1977.

SOURCE: Health Care Financing Administration

States is now in the mid 60%. It is below 50% in many regions. American physicians, for their part, have for years deplored a growing physician surplus.

This enormous capacity and excess capacity comes at a stiff price. As is shown in Table 4 and Figure 4 below, no other country now operates as expensive a health system as does the United States, and therein lies a major ethical problem:

So expensive has American health care become that the nation's middle-and upper-income classes now seem increasingly unwilling to share the blessings of their health system with their millions of low-income, uninsured fellow citizens. The gentleness and kindness for which Americans had come to be known after World War II has, thus, literally been priced out of the nation's soul. By international standards, American health policy towards the poor--particularly towards poor children--now appears rather callous.

[Table 4, Figure 4]

B. The Uninsured

At this time, some 35 million Americans, about three quarters of them full-time employees and their dependents, and about one third of them children, have no health insurance coverage of any form. Most of these American families have incomes below \$20,000 per year, yet for such families, if they are healthy, an individually purchased commercial insurance policy with considerable cost sharing would now cost anywhere between \$ 3,000 to \$ 4,000 per year, and some insurance companies have ceased to offer such policies even at these prices because they are unprofitable. If such families have chronically ill members, however, a private health-insurance policy may not be available to them at all.

Such enormous gaps in health-insurance coverage are not known anywhere else in the industrialized world. As noted above, without exception, the other member-nations in the Organization for Economic Development (OECD) offer their citizenry *universal* health-insurance coverage for a comprehensive set of health services and supplies, typically including dental care and prescription drugs (with the exception of Canada, where these items are covered only for low-income families).

Traditionally, the American health system has dealt with the uninsured thus: for mild to semi-serious illness, care to the uninsured has been effectively rationed on the basis of price and ability to pay. For critically serious illness, however, care was generally made available through the emergency rooms of hospitals who then shifted the cost of that

TABLE 4

Total Health Expenditures As A Percentage Of Gross Domestic Product, 1970-1989

	1970	1975	1980	1985	1986	1987	1988	1989
Australia	4.9%	5.5%	6.5%	7.0%	7.1%	7.1%	6.9%	7.0%
Austria	5.4	7.3	7.9	7.6	8.3	8.4	8.3	8.2
Belgium	4.1	5.9	6.3	6.9	7.2	7.3	7.3	7.2
Canada	7.1	7.2	7.4	8.5	8.8	8.8	8.6	8.7
Denmark	6.1	6.5	6.8	6.3	6.0	6.3	6.4	6.3
Finland	5.7	6.3	6.5	7.2	7.4	7.4	7.2	7.1
France	5.8	7.0	7.6	8.5	8.5	8.5	8.6	8.7
Germany	5.9	8.2	8.5	8.6	8.5	8.6	8.9	8.2
Greece	4.0	4.1	4.3	4.9	5.4	5.2	5.1	5.1
Iceland	5.2	6.2	6.5	7.4	7.8	7.9	8.5	8.6
Ireland	5.6	7.6	9.0	8.3	8.3	8.0	7.9	7.3
Italy	5.2	6.1	6.8	7.0	6.9	7.3	7.6	7.6
Japan	4.4	5.5	6.4	6.5	6.7	6.8	6.7	6.7
Luxembourg	4.1	5.6	6.8	6.8	6.7	7.2	7.3	7.4
Netherlands	6.0	7.7	8.2	8.2	8.1	8.5	8.4	8.3
New Zealand	5.2	6.7	7.2	6.6	6.9	7.3	7.4	7.1
Norway	5.0	6.7	6.6	6.4	7.1	7.5	7.4	7.6
Portugal	-	6.4	5.9	7.0	6.6	6.4	6.5	6.3
Spain	3.7	4.8	5.6	5.7	5.6	5.7	6.0	6.3
Sweden	7.2	7.9	9.5	9.3	9.0	9.0	9.0	8.8
Switzerland	5.2	7.0	7.3	7.6	7.6	7.9	8.0	7.8
Turkey	-	3.5	4.1	-	-	3.5	-	-
United Kingdom	4.5	5.5	5.8	6.0	6.0	5.9	5.9	5.8
United States	7.4	8.4	9.3	10.6	10.8	11.1	11.3	11.8
Mean*	5.4	6.5	7.1	7.4	7.4	7.6	7.6	7.6

Source: Health OECD, *Facts and Trends* (Paris: OECD, forthcoming).

* Mean excluding Turkey.

Source: George J. Schieber and Jean-Pierre Poulletier, "International Health Spending: Issues and Trends" *Health Affairs*, Spring, 1991; p. 109.

charity care (including needed inpatient care) to paying patients, notably those insured by the business sector.

Unfortunately, in recent years this source of charity care has begun to dry up as the profit margins of hospitals have come to be squeezed by a combination of excess capacity and downward price pressure on the part of both the public- and private-sector payers. On average, an uninsured, low-income American now receives only about 50% to 60% of the health care received by an identical, regularly insured American.

Thus, the myth that, unlike other nations, America does not ration health care is just that, a myth. Americans do ration health care by price and ability to pay, sometimes in rather disturbing ways.

C. Styles of Rationing

The preceding observation suggests that nations differ from one another not by whether or not they do ration health care--all of them do somehow and to varying degrees--but in their style of rationing.

One style is to limit physical capacity and then to use triage based on medical judgement and the queue to determine the allocation of artificially scarce resources among the populace. That style of rationing is sometimes referred to as *implicit rationing*.

The other style is to ration *explicitly* by price and ability to pay. It is the natural by-product of the so-called "market approach" to health care.

Implicit rationing predominates outside the United States. In principle, the approach is thought to allocate health care strictly on the basis of medical *need*, as perceived and ranked by physicians. It is not known whether or not other variables, such as the patient's social status, ultimately do enter the allocation decision as well. For example, one wonders whether a gas station attendant in the United Kingdom has quite the same degree of access to limited resources as does, say, a barrister or university professor who may be able to use social connections in attempts to jump the queue.

As noted, many Americans believe that health-care is not now rationed in the United States. That belief seems warranted for well-insured patients who are covered by traditional, open-ended indemnity insurance, and who are living in areas with excess capacity. For many such patients, there seems to be virtually no limit, other than

nature, to the use of real resources in attempts to preserve life or to gain certainty in diagnosis. On the other hand, persons who are less well insured, who are uninsured, or who are covered by managed-care plans (including HMOs) do on occasion experience the withholding of health-care resources strictly for economic reasons. In fact, in a recent cross-national survey, some 7.5 percent of the respondents (the equivalent of 18 million Americans) claimed that they had been denied health care in the previous year for financial reasons. In Canada and the United Kingdom, much fewer than 1 percent of the respondents made that claim².

Remarkably, it seems easier to implement the *implicit*, supply-side rationing practiced in most other countries than it is to use the *explicit* American approach to rationing. In the previously cited survey, Americans appeared much less satisfied with their health-care system now than were Canadians and British respondents reacting to the identical set of questions on the subject.³

For some reason, both physicians and patients appear to accept with greater equanimity the verdict that needed capacity is simply not available than they do the verdict that available, idle capacity will not be made available because some budget has run out⁴. Thus, while the American approach to rationing does work after a fashion, it tends to create greater rancor among both patients and physicians than does the *implicit* rationing practiced elsewhere in the world. No one likes to see monetary factors enter medical decisions quite so blatantly at the patient's bedside as *explicit* rationing requires. Yet, a nation bent upon using the market approach to health care ultimately cannot escape those troubling acts.

D. Summary on the Economic Footsteps

To sum up at this point. There appears to be a trade-off in the organization of health care that simply cannot be avoided: it is a trade-off among three distinct desiderata in health care, namely, (1) the freedom granted the providers of health care to organize the production of health care as they see fit and to price their products and services as they see fit, (2) the degree of control over total health care expenditures and (3) the degree of equity attained in the distribution of health care. Figure 4 illustrates this trade-off schematically.

[Figure 4]

² See Robert J. Blendon, "Three Systems: A Comparative Story," *Health Management Quarterly*, Vol. XI, No.1, First Quarter, 1989; pp. 2-10.

³ *Ibid.*

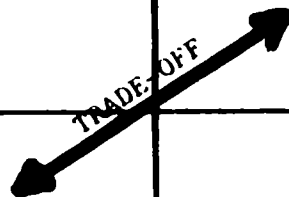
⁴ In this connection, see also the fascinating analysis of this facet of British health care in Henry J. Aaron and William B. Schwartz, *The Painful Prescription*, Washington, D.C., The Brookings Institution, 1984.

FIGURE 4

Competing Objectives In Health Care: Basic Prototypical Systems That Span The Set Of Actual Systems

— DESIDERATA —

Egalitarian Distribution	Freedom From Govern- ment Interference in Pricing and in the Practice of Medicine	Budgetary and Cost Control	Prototypical System
YES	YES	NO	The Health-Care Pro- vider's Dream World
YES	NO	YES	A National Health Insurance System with Fee Schedules and Other Utilization Review. (e.g., Canada, West Germany)
NO	YES	YES	A Price-Competitive Market System



IV. THE CONVERGENCE OF HEALTH SYSTEMS

Remarkably, just as Americans are growing increasingly disillusioned with their so-called *market-approach* to health care, many European analysts have combed through the American experience to see what facets of the *market approach* might be grafted upon the European systems. Quite possibly, in the early next century, these distinct systems will have converged somewhat towards a middle ground that seeks to combine firm adherence to the principle that basic health care *is a social good*, but that also seeks to afford patients considerable choice in the setting in which they receive their care and in the terms on which they procure it.

Several developments in the global economy may contribute to that trend.

First, there is the ever greater mobility of not only tradeable goods, but also of capital and of labor across international frontiers. Unskilled labor in one country will compete with unskilled labor anywhere else in the world, and financial and human capital will flow across borders towards their most profitable uses. These flows may well pull further apart the currently narrow income distributions in the industrially advanced economies. There arises the question whether those fortunate enough to be endowed with ample financial or human capital (education)--let us call them *Euro-yuppies*-- will be quite as willing as they are now to share the full blessings of their health system with their brethren and sisters in the lower income strata.

That question may be sharpened by a second international trend: the breathtaking development of new medical technology. While one may hope that much of that technology will ultimately *lower* the cost of restoring patients to good health, recent trends have not been encouraging: by and large, new techniques of imaging and intervention have been cost-increasing. In line with the preceding question, one may ask whether tomorrow's *Euro-yuppies* may not share the emerging ethics of their American counterparts, an ethic best described ably the slogan: *God bless me, and to hell with you!*

Perhaps the best that can be hoped for by those who would like to see health care treated as a *social good* would be a system that seeks to guarantee all citizens afflicted with a given medical condition the same survival and cure rates, but that allows multiple tiers in terms of the amenities of the setting in which health care is received, of the freedom of choice among doctors and hospitals afforded the patient, of the immediacy of access to care and of yet other terms on which health care is received.

In the United States, for example, this might mean that middle and lower-income Americans would be guaranteed access to basic health care through a small set of competing Health Maintenance Organizations, while upper-income patients will continue to have access to insurance policies affording them completely free choice of providers and instant access to whatever health care their money can buy. For the millions of currently uninsured Americans, that would be a marked improvement.

APPENDIX A

SPENDING ON HEALTH CARE IN THE UNITED STATES:

The Long-Run Perspective

During the past two decades or so, share of the United States Gross National Produce (GNP) "going to health care" has grown substantially. In fact, the average annual compound growth rate of total health spending in the United States has been close to 3 percentage points higher than the comparable growth rate in the non-health components of the GNP. During the past five years, that differential has actually widened. At this time, it exceeds 3 percentage points, in part, of course, because GNP is not growing very rapidly.

Figures A-1 and A-2 project the past experience into the future. In these projections, letter **h** denotes the annual compound growth rate in national health spending and letter **g** the corresponding growth rate in non-health gross national product. Because these projections are based on the average long-run experience during the past two decades and are anchored in 1990, they sit a bit lower than do the projections that have been offered more recently. As is indicated in Figure A-1, these more recent estimates, based on the period since 1985, have national health spending reach about 17% of the GNP by the year 2000, versus about 9% in 1980 and about 13 % in 1991.

By way of contrast, Figure A-3 provides a cross-national perspective on health spending. It is seen that the United States allocates by far the largest share of its GNP to health care among the countries listed in Figure 4 and, indeed, in the world. It can be expected that, by the year 2000, the spending gap between the United States and the rest of the world will have widened, because most other industrialized nations now try to tie the growth of their health spending to the growth in their GNP. The United States has never attempted to do so. In the short run--the next decade or so--the United States probably could not do so even if it tried.

FIGURE A-1
HEALTH CARE AS PERCENT OF THE GNP
UNDER DIFFERENT ASSUMPTIONS

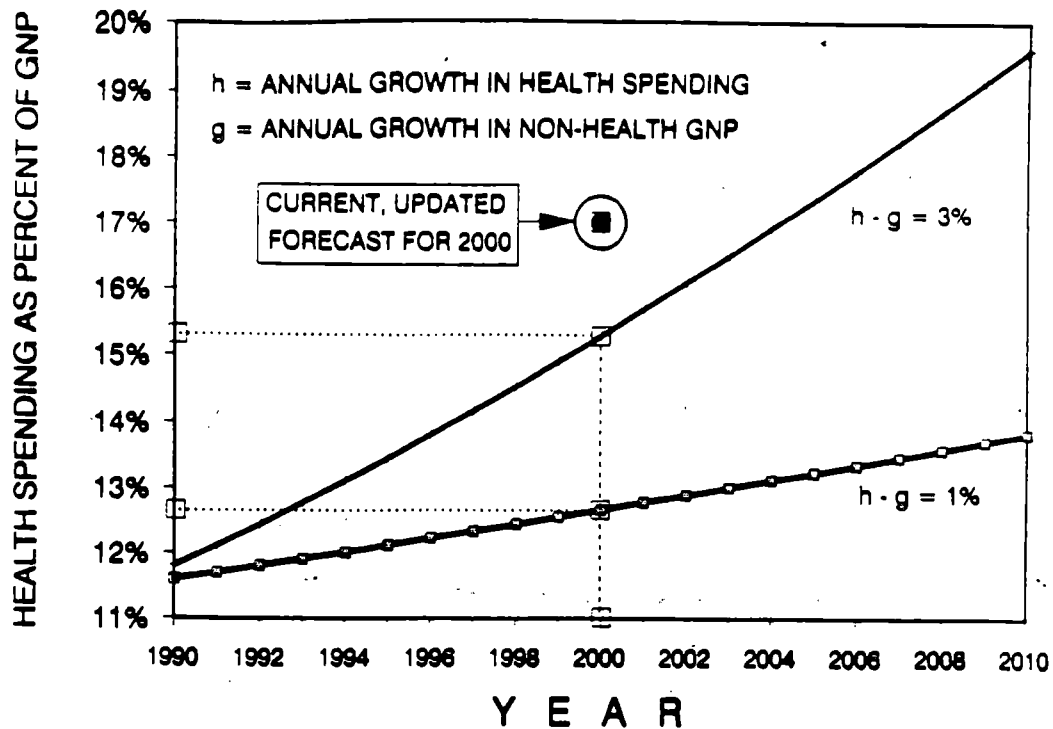


FIGURE A-2
HEALTH CARE AS A PERCENTAGE OF THE GNP
UNDER DIFFERENT ASSUMPTIONS

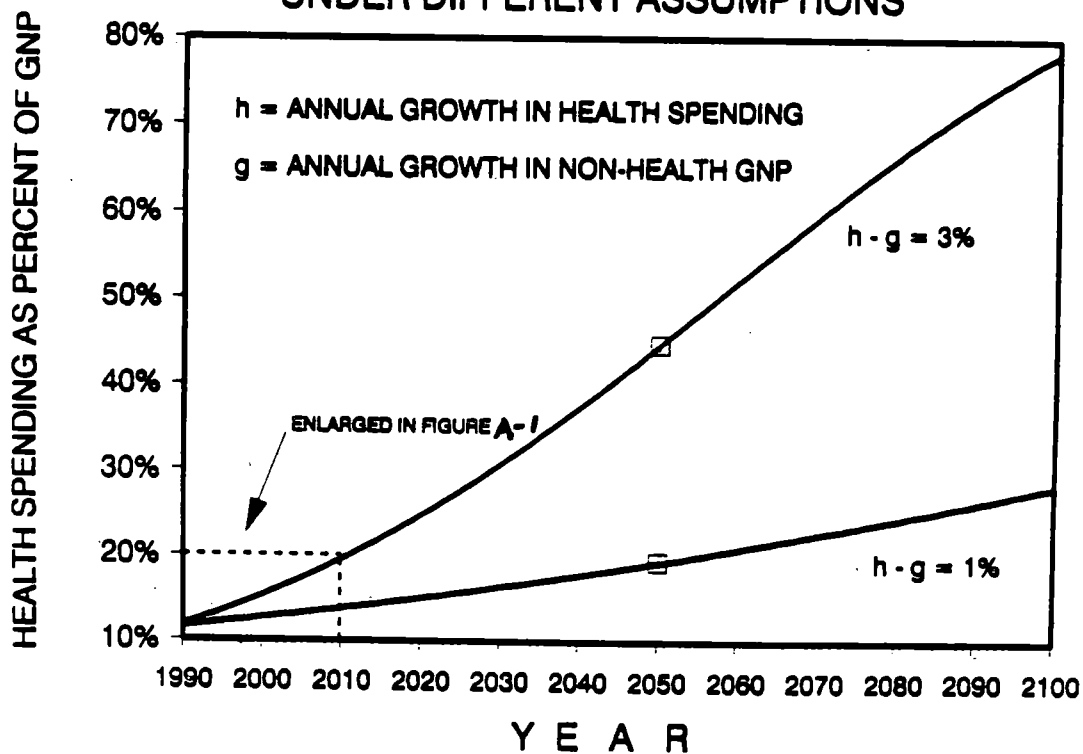
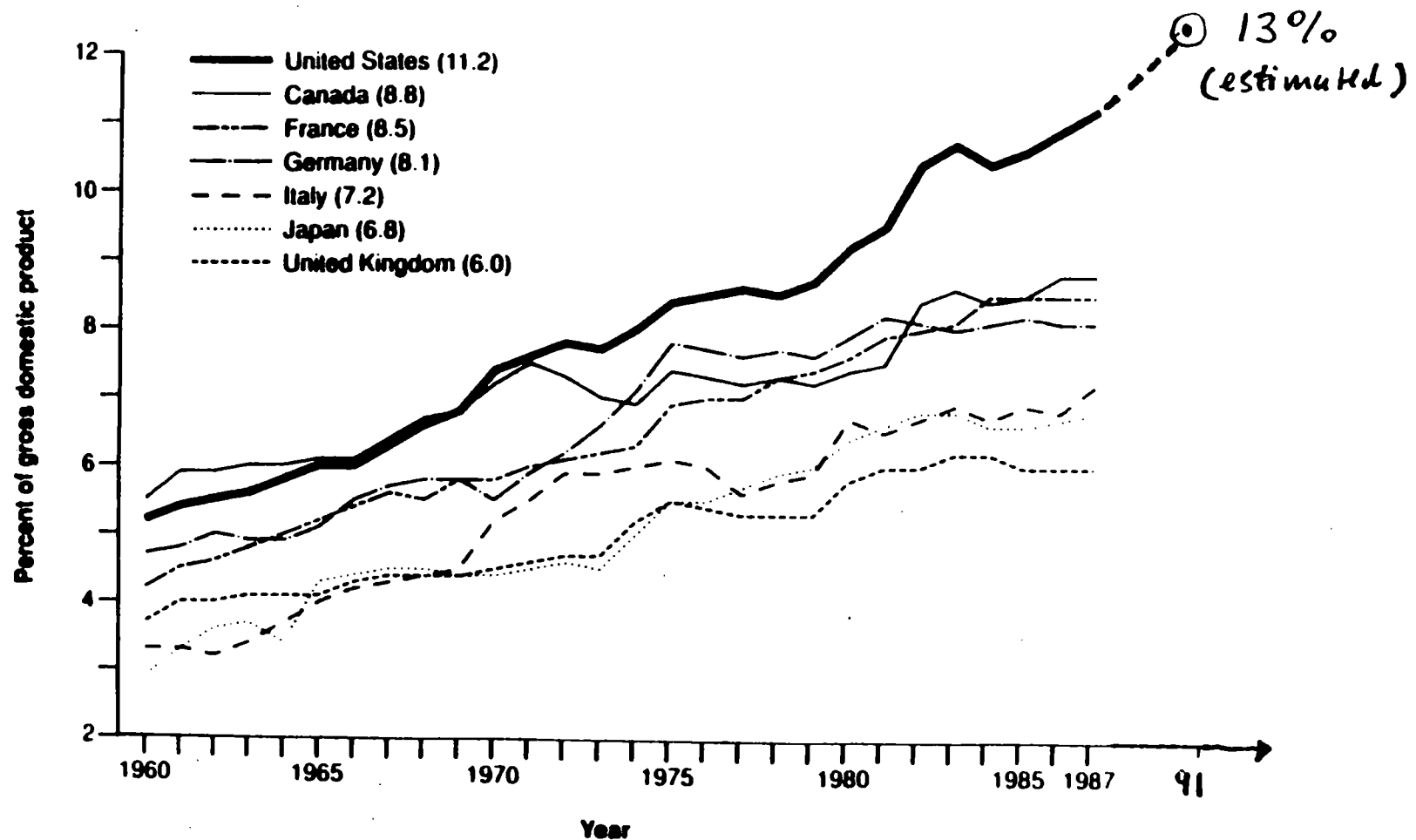


FIGURE A-3

Total health expenditures as a percent of gross domestic product: Selected countries, 1960-87



NOTE Countries are listed in descending order based on the share of gross domestic product devoted to health for 1987 (in parentheses)

SOURCE Organization for Economic Cooperation and Development Health care expenditure and other data. An international compendium *Health Care Financing Review* 1989 Annual Supplement HCFA Pub No 03291 Office of Research and Demonstrations. Health Care Financing Administration Washington U S Government Printing Office. Dec 1989

Source: George J. Schieber, "Health Expenditures in Major Industrialized Nations," *Health Care Financing Review*, Summer 1990; Figure 1.

APPENDIX B

Excerpts from

**HEALTH CARE SPENDING CONTROL:
The Experience of France, Germany and Japan.**

**Report GAO/HRD-92-9 of the
U.S. General Accounting Office**

**Washington, D.C.
November, 1991**

Executive Summary

Purpose

For two decades, the growth of health care spending in the United States has outpaced the growth of the rest of the economy—a pattern with troubling consequences for business, consumers, and government. Persistent pressures caused by rising spending have called forth various remedies, but success in containing spending has been elusive.¹ Consequently, policymakers and analysts have sought insights from the experience of industrialized countries that appear to control spending growth better, provide universal access to health care, enjoy better health, and spend a smaller share of their national income on health care.

The Ranking Minority Member, Senate Special Committee on Aging asked GAO to report on the lessons that the United States can draw from industrialized countries that spend less on health care. The Chairmen of the Senate Governmental Affairs Committee and the Senate Special Committee on Aging later joined in this request. In response, this report (1) describes how three of these countries—France, Germany, and Japan—organize their health insurance systems, achieve universal coverage, and regulate payments to providers; (2) describes the policies used in each country to contain spending for physician and hospital care; and (3) determines whether these policies were effective in moderating the rise in health spending.

Background

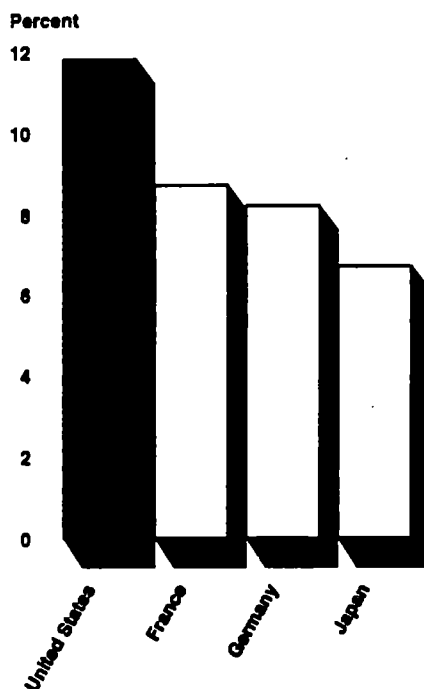
A rapid escalation in spending and a noticeable narrowing of access characterize the recent experience of the U.S. health care system. Between 1970 and 1990, the share of national income spent on health care grew by more than half: from 7.3 percent of gross national product (GNP) in 1970 to 12.3 percent in 1990; projections to the year 2000 imply a share that would most likely exceed 16 percent. Notwithstanding the high and rising level of spending, more people lack ready access to health care. Between 1979 and 1987, the number of Americans without health insurance rose by a fourth—from 29.9 million to 37.4 million.

Other industrialized countries have had more success than the United States in controlling health care spending while also providing health insurance to virtually all their citizens. For example, France, Germany, and Japan each spends a significantly smaller share of its national income on health care than does the United States (see fig. 1). The lower spending in these countries has not meant less access to basic health

¹The consequences of rising health spending are described in *U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform* (GAO/HRD-91-102, June 7, 1991), pp. 8-11; the record of various spending control initiatives is reviewed in the same report, pp. 14-16.

services or deterioration in broad measures of health status, such as life expectancy and infant mortality.

Figure 1: Health Care Spending as a Share of Gross Domestic Product (1989)



This study examines the policies that have been used in France, Germany, and Japan to control health care spending. In conducting this analysis, GAO obtained data on health expenditures and health status, reviewed literature on each country's health care system, and interviewed experts from the United States and from each of the countries reviewed. GAO also analyzed the likely effects of various spending control policies and statistically estimated the effects of several policies' effectiveness. Our statistical analysis was limited to France and Germany for technical reasons.²

Results in Brief

France, Germany, and Japan achieve near-universal health insurance coverage within health care systems that share three major traits with

²Unlike Japan, France and Germany made major changes in reimbursement policy during the 1970s and 1980s; those changes permitted the necessary before-and-after comparison between spending under the new policy and spending under the previous policy.

the U.S. system: (1) medical care is provided by private physicians and by both private and public hospitals, and patients have free choice of physician; (2) most people receive health insurance coverage through their workplace; and (3) health insurance is provided by multiple third-party insurers.

These similarities to the U.S. system coexist with several notable differences that follow from the far-reaching regulations used to guarantee coverage. First, insurers—who are predominantly non-profit—are required to provide minimum coverage that includes a wide range of health care benefits. Second, insurance enrollment is compulsory (with minor exceptions) for all residents, and they have little or no choice of insurers. Third, workplace-based insurance is financed not by premiums that reflect each individual group's expected costs of care, but largely by employer and employee payroll contributions that reflect the average cost of a larger cross section of the population.

In addition to mandating insurance coverage, all three countries standardize reimbursement rates for almost all physicians and hospitals and set ceilings (price controls) on these rates.³ Virtually all payers must, when reimbursing providers, abide by the standardized rates. Reimbursement rates are not promulgated by the government unilaterally, but emerge from formal or informal negotiations between physicians, hospitals, third-party payers, and (in France and Japan) the government.

Budget controls—policies that augment price controls by setting limits on overall spending for hospital care or for physician services—can moderate spending growth, particularly when they are enforced. Each country sets limits on overall health spending as national goals, but only France and Germany have added policies with teeth to achieve compliance with the limits. GAO estimated that French budget controls, between 1984 and 1987, reduced real (inflation-adjusted) hospital spending by as much as 9 percent, compared with what would have been spent had price controls alone been used. Likewise, GAO estimated that for physician care services, German budget controls reduced real spending by as much as 17 percent between 1977 and 1987, compared with what would have been spent without the budget controls. By contrast, overall spending limits on German hospitals did not reduce spending growth;

³In addition, all three countries have some controls on spending for hospital construction or the purchase of new, high-cost medical equipment.

these limits were not, however, accompanied by a mechanism to achieve compliance.

The budget controls that successfully moderated spending growth in France and Germany are not a panacea for concerns about spending. Budget controls have not relieved all pressures on spending, in part because these controls have not been applied to all segments of the health care industry. Moreover, budget controls do not assure high-quality care or efficient delivery of services. In light of these concerns, both France and Germany are exploring modifications and supplements to their current strategies for controlling the rise in health spending.

GAO's Analysis

Three Countries' Health Care Systems Retain Private Medicine, Patient Choice

In France, Germany, and Japan, as in the United States, patients generally can choose their own physician; outpatient services are provided by private physicians; and inpatient care is provided in both private and public hospitals. Physicians who provide outpatient services are paid on a fee-for-service basis—as are most U.S. physicians. (Unlike in the United States, however, physicians who deliver inpatient care are often employed by a hospital on a salaried basis.)

Countries Provide All Residents With Health Insurance Through Regulated Multipayer Systems

Each country guarantees virtually all their residents health insurance that offers a broad minimum level of benefits. Near-universal coverage is achieved by making enrollment for health insurance compulsory, with few exceptions, and virtually automatic. Health insurance is provided through a diverse mix of third-party payers that emerged from each country's particular social institutions and political history. Independent action by each payer is limited due to national regulation of enrollment, benefits, premiums, and reimbursement of providers.

Broad Package of Benefits Is Mandated

The mandated package of health benefits covers a wide range of services. Benefits generally include coverage for physician services, hospital care, laboratory tests, prescription drugs, and some dental and optical care. Patients in all three countries do not pay deductibles for health care services; copayments for physician and hospital care range from nominal amounts in Germany to as much as 20 to 30 percent of regulated fees in France and Japan.

Insurance Financed by Payroll-Based Contributions From Employer and Employee

Workplace-based insurance in France, Germany, and Japan is largely financed by mandatory payroll contributions from both employees and employers. In contrast to private insurance financing in the United States, which generally reflects each individual group's expected costs of care, these mandatory contributions reflect the average cost of a larger cross section of the population than typically used by U.S. insurers in calculating premiums. (In France and Japan, payroll-based financing is supplemented by subsidies from general tax revenues.)

Countries Set National Limits on Spending and Require Uniform Payment Rates

Each country has national procedures for setting limits on health care spending and for determining standardized reimbursement rates for providers. Generally, a government agency or other authorized body sets broad targets for all or some components of health care spending. The targets may serve as guidelines or they may be binding. National laws also require that payers reimburse providers according to rates that are, for the most part, uniform; a given service is usually reimbursed at the same rate, regardless of payer.

Each country also has a formal process for setting payment rates for physicians and hospitals. The health care system's major stakeholders—third-party payers, physicians and hospitals, and (in France and Japan) the government—participate in this rate-setting process. In France and Germany, the rates are set in formal negotiations. In Japan, they are set by the government in consultation with a body that represents insurers and health care providers.

Countries Adopt Direct Controls on Prices and Overall Spending

Seeking to moderate the rise in health care spending, all three countries have imposed direct controls on health care prices and overall spending. These controls are comprehensive—applying to the entire health care industry or to a major health care sector. By use of standardized payments, mandated coverage, and mandated benefits, the three countries have alleviated a potential problem with direct controls, known as cost shifting (that is, providers offset both the cost of charity care and the lower reimbursement from some patients' insurers by raising charges to other, more generous insurers).

Budget Controls With Teeth Work Better Than Price Controls at Containing Spending

France and Germany implemented budget controls that were subject to different degrees of enforcement— Germany, starting in the late 1970s; France in the mid-1980s. These controls supplemented or replaced price controls that were already in place. Both countries set annual targets to limit total spending on hospital services, and Germany set targets and, later, caps to limit total spending on outpatient physician services. GAO's econometric analyses confirm that stringent enforcement makes budget controls more effective.

Hospital Spending in France and Germany

Spending limits restrained hospital spending in France but not in Germany. Beginning in 1984, the French government replaced its fixed daily rates for hospital care with targets for total public hospital spending. To enhance compliance with the targets, the government participates in budget negotiations with each individual public hospital. GAO estimates that between 1984 and 1987, the targets reduced French spending on hospitals by about 9 percent below what would have been spent had price controls remained in place. By contrast, Germany in 1985 established targets for total hospital spending, but did not design the means to enforce them. GAO found no statistical evidence that the existence of targets affected German spending for total hospital services between 1985 and 1987.

Physician Care Spending in Germany

Stringent enforcement enhanced the effectiveness of Germany's budget controls on physician spending. In 1978, Germany complemented its existing price controls with spending targets (though not with a formal enforcement mechanism). In 1986, however, Germany replaced targets with caps that were binding. GAO estimates that between 1977 and 1987, Germany's use of budget controls reduced inflation-adjusted spending by as much as 17 percent below what would have been spent on physician care under price controls alone. In addition, GAO found that caps reduced the rate of spending growth more than targets. Spending growth in the physician sector averaged 2 percent annually under caps, compared with 7 percent annually under targets; caps account for part, but not all, of this difference.

Countries Seek Additional Policies to Better Restrain Spending, Assure Quality, and Enhance Efficiency

In the countries reviewed, budget controls that successfully tempered the pace of spending growth have not relieved all pressures on spending, nor have they attempted to address concerns about the quality and efficiency of health care. Increased spending can be attributed, in part, to sectors not controlled through budgets, such as physician services in France or prescription drugs in all three countries. Continued pressure to increase health care spending in the future is also expected, as the

elderly's share of the population rises further and new, expensive medical treatments are introduced.

In addition, the continued tightening of budget controls may, over time, both create political pressures for a relaxation of the controls and make a health care system less able to provide high-quality services. In France, new proposals for stronger budget controls recently sparked widespread protests by physicians. In Germany, some controls on physician spending were relaxed in mid-1991 due to pressure applied by physicians. With respect to quality, GAO found no evidence in the countries reviewed of a decline in broad measures of health status during the relatively brief period that budget controls were in effect. Experts in France, however, believe that tight hospital budgets there are discouraging hospital maintenance and the development of innovative procedures. In other countries that have used budget controls for longer periods than France and Germany, some shortages of services have appeared, indicating the potential for problems in the long run.

Health care experts in these three countries are exploring policies that enhance efficient delivery and better assure quality. For example, efforts are being made in France and Germany to develop a prospective payment system for hospitals—following the same general principles used in the U.S. Medicare program since 1983—that offers incentives for more efficient delivery of hospital care. Germany is developing programs that enhance quality by increasing physician monitoring, formalizing quality assurance procedures, and increasing the coordination of inpatient and outpatient services.

Recommendations

GAO is not making recommendations in this report.

Agency Comments

GAO did not solicit agency comments.

Chapter 2
Multipayer Systems Achieve Universal
Coverage and Set Spending Goals and
Uniform Rates

Table 2.1 Health Insurance Benefits in France, Germany, and Japan

	France	Germany	Japan
Outpatient services and inpatient hospital care	Most treatment and diagnostic services covered		
Maternity care	Prenatal, maternity, and well-baby care services are covered Cash benefit—about US\$150 a month—paid for 9 months (5 months before birth, the birth month, and 3 months after birth) Additional 16-week maternity leave paid to mother; rate is based on previous income and is limited to a maximum of about US\$50 a day	All necessary medical care covered Cash benefit paid 6 weeks before and 8 weeks after birth Home nursing for women in "childbed"	Costs not specifically covered by health insurance system, but rather by public health programs Cash benefits for childbirth and for mother's loss of wage income (for up to 6 weeks before birth and 8 weeks after)
Preventive care	Covered care includes (1) free preventive exam every 5 years and (2) mammographies for women over the age of 45 Immunizations also provided; funding comes from government	Preventive medical exams for (1) children to the age of 6, (2) women over the age of 20, (3) men over the age of 45, and (4) health check-ups after the age of 35	Generally covered by workplace-based insurance; not covered by public insurers, although local governments provide screening at little or no cost
Dental and optical care	Covered items include basic dental care, dentures, and eyeglasses	Preventive check-ups for people aged 12 to 20 Partial payment of dentures and crowns Cost of eyeglasses	Dental services covered
Long-term care	Home care services, day care, and some inpatient chronic care services are covered	Long-term care given in the hospital setting, rather than in a nursing home or other chronic care setting, is covered by the insurance system	Services are covered, but there are few nursing homes or other long-term care facilities; long-term care provided by hospitals is covered

(continued)

Chapter 2
Multipayer Systems Achieve Universal
Coverage and Set Spending Goals and
Uniform Rates

	France	Germany	Japan
Prescription drugs	Covered, subject to some restrictions	Covered, subject to some restrictions	Covered
Income maintenance	Generally, workers are entitled to 50 percent of wages, up to about US\$33 a day, for up to 360 days in any 3-year period (for certain diseases, such as cancer, benefits may be granted for an unlimited number of days, for up to 3 years)	Income support, for the most part, of up to 80 percent of lost income (not to exceed total net income), for up to 78 weeks in any 3-year period	Income support, of up to 60% of standard daily wage (40% if insured person has no dependents and is hospitalized), paid for up to 18 months
Cost sharing by patients	Standard cost-sharing rates: (1) 25% for physician visits, (2) 20% for hospital services, up to the 30th day of care (and 0% afterwards), plus a US\$6 fee for daily room charges, (3) 30% for laboratory tests and dental services, and (4) 30%-70% for covered prescription drugs, depending on the necessity of the medication; patient must bear full costs of other (uncovered) prescription drugs Cost sharing for poor people is paid for by the social welfare system Cost sharing for hospital costs waived for maternity care and for certain high-cost illnesses	Limited cost sharing for hospital care (about US\$6 a day) Cost sharing for some prescription drugs	Cost sharing ranges from 10% to 30% of costs, depending on insurance carrier, whether insured is an employee or a dependent (dependents sometimes have higher cost sharing) or whether treatment is in a hospital or in an outpatient setting Cost sharing waived after monthly payment reaches catastrophic cap of about US\$400 (US\$200 for low-income people)

Payroll-based Financing

Workplace-based insurers are largely financed through mandatory payroll contributions from both employees and employers (see fig. 2.1). This contrasts with the financing of most U.S. insurers, which is done through premiums that reflect actuarial estimates of expected future illnesses and health care expenses of an enrolled group. In France and Japan, payroll-based financing is supplemented by subsidies from general tax revenues.

**Figure 2.1: Financing of Mandated Health
 Insurance in France, Germany, and
 Japan**

Country	Financing Structure	Government Subsidy
France	Source of Funds: Mandatory Payroll Contributions Contributions: Determined by Central Government Employers' Share – 12.6% of Total Wage Bill Employees' Share – 6.8%^a (No Wage Ceiling)	Subsidies From General Revenue and Specific Taxes
Germany	Source of Funds: Mandatory Payroll Contributions Contributions: Determination by Individual Sickness Funds Contribution Shared Equally by Employer and Employee Average: About 13% of Wages Range: 8% – 16% of Wages, Subject to a Wage Ceiling	No Government Subsidy
Japan	Source of Funds: Mandatory Payroll Contributions Contributions: Determined by the Individual Carrier Average: About 8% of Standard Monthly Salary Employer Pays at Least 50% of Contribution Range: 3.5% – 13.3% of Salary	Central Government Pays Most Administrative Costs^b Subsidies to Some Insurers: (for Some of the Insurance Societies) to 52 % of Costs

^aEmployee contribution rate was 5.9 percent before July 1991.

^bLocal governments in Japan pay the administrative costs of the mutual aid associations (insurers) that cover local public service employees.

Use of Regional Planning to Allocate Construction and High-Cost Medical Equipment

France

Hospital construction must be approved by national government. Any addition of hospital beds must be offset by closings elsewhere.

High-cost medical equipment must be authorized by national government.

Germany

Hospital construction and high-cost medical equipment are licensed and financed by the states.

Japan

Hospital construction subject to regional planning, but limits do not apply to private clinics (defined as facilities with less than 20 beds).

No planning to control growth or distribution of high-cost medical equipment.

The U.S. Health Care System

It is hard not to be startled by contemporary developments in U.S. health care. Almost every day we learn about yet another discovery or a new medical treatment. Unfortunately, we also hear about escalating costs and about growing evidence that some medical practices may have minimal impact on our well being.

Like many others, I have been giving more thought to how we provide health care services in this country. But I also have two special reasons for this increased attention: First, I am teaching a graduate-level workshop this fall in health economics and policy with Professor Uwe Reinhardt, one of the nation's leading experts in the field. Second, I am chairing a study committee of the Institute of Medicine of the National Academy of Sciences on the viability of important aspects of our health care financing and delivery systems. I would like to take this opportunity to share just a few of my initial thoughts about both the successes and the failings of the U.S. health care system.

First, it is important to recognize that there have been many successes. We lead the world in basic biological research and in the development of new medical technologies and treatments. Large groups of our population have access to health care that was unknown to earlier generations and the quality of treatment at most of our acute care hospitals and ambulatory clinics far surpasses that of earlier times.

At the same time, the overall health status of Americans has shown less dramatic improvement; we continue to experience relatively high infant mortality rates and relatively low immunization rates; and the number of Americans who lack health insurance, are underinsured, are underserved, or are otherwise medically indigent has reached alarming levels—particularly among children, young adults, poor people, and certain population groups such as Native Americans. If one believes a just society requires that a minimum standard of care should be available to all, we have not fulfilled this requirement.

The distinctive characteristics of the U.S. health care system include: an emphasis on voluntary participation (e.g. employment-based private health care insurance) and consumer choice; strong incentives for the consumer to demand more and the provider to prescribe more; tax incentives for both purchasers and providers; substantial public finance (Medicaid and Medicare), despite a lack of coherent overall public health care policy; modest control over prices; unusually high investments in research and advanced training; and higher administrative costs than in other countries. It is a system that serves many exceedingly well, but others not at all.

The costs of the American health care delivery system are by far the highest in the world: 40 percent more expensive than our closest rival (Canada) and nearly 100 percent more expensive than our next closest (Germany). Moreover, our costs continue to rise rapidly. There are many reasons for these high costs, including an aging population, new technologies, practices that are highly capital intensive, underinvestment in prevention, malpractice claims, increasing fragmentation of the insurance market, the social disorganization of certain communities, the escalation of physician fees, and increasing substance abuse. Unfortunately, a decade of cost containment initiatives by employers, unions, governments and others seems to have had little effect, and there is growing concern that we are not getting



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sufficient additional value for all of this additional expenditure.

There also is growing concern about those who lack access even to basic medical care. Part of the problem is that some employers do not offer health insurance coverage (one-half of the uninsured are employed); many part-time employees are not covered; coverage for the dependents of employees is declining; there are growing gaps in the Medicaid program; and certain geographic areas are without appropriate health care facilities and/or personnel. No society can provide access for everybody to everything, but the fact that some 35 million Americans are without health insurance coverage for even the most basic services, despite our very high level of expenditures and our enormous expertise, strikes many as a national scandal.

What is most striking about the United States' approach to health care is our national inability to decide whether basic health care is a social good that is intrinsically related to individual liberty, independence, and equal opportunity and therefore a collective obligation, or a private good to be left to individual responsibility. We cannot decide whether the goal of health insurance programs is simply to protect against unexpected events (like automobile insurance), or if it is also a mechanism for achieving universal access to basic health services, regardless of an individual's financial situation. (A decision to finance the provision of basic health insurance collectively does not mean that health care providers need to become government-run organizations. One can collectivize responsibility without collectivizing production.)

Not surprisingly, there have been many suggestions for reform, with most proposals seeking primarily to improve access and/or contain cost. The limitations of space do not permit me to discuss all of them here. But I would like to mention a few of the convictions that I have been moving toward regarding some of the general characteristics that I believe our system of health care should acquire as it evolves:

(1) We need to assure the availability and affordability of basic health care coverage for everyone. In spreading risks and costs more "fairly," and in subsidizing the unemployed, the poor, retirees, and low wage workers, this inevitably will involve some transfer of resources from the rich to the poor and from the healthy to those with disease.

(2) We should not permit health insurance premiums to be sharply influenced by differential health status and/or prospects. Eventually such differentials will undermine any system for providing universal basic health coverage.

(3) We need both some sort of managed negotiation between payers and providers and heightened cost consciousness by patients to achieve greater constraints on cost increases.

(4) Societies' different approaches to social support programs, including health care, reflect differing values and cultural histories. As our system evolves we should not simply copy others, but we should learn from them as we build upon our own values and history.

Any serious proposal for change must provide further detail on a wide variety of issues (rationing of care, oversight of our national investment in health care technology and facilities, staffing patterns and responsibilities, etc.), but it seems to me that we need to begin by agreeing on some set of fundamental objectives. I look forward to testing, refining, and expanding my understanding of these objectives in the classroom this fall and as the Institute of Medicine committee pursues its responsibilities during the coming year.

"... the fact that some 35 million Americans are without health insurance coverage for even the most basic services ... strikes many as a national scandal."

Figure 1.2: Growth in Real Health
Spending Per Capita (1980-89)

60 Percent

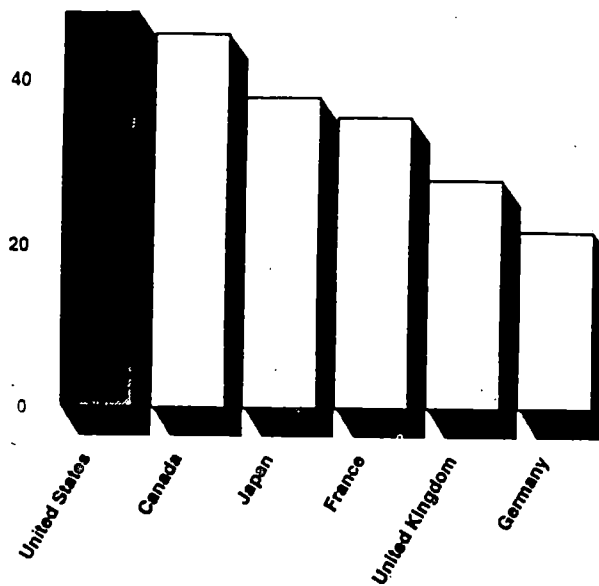
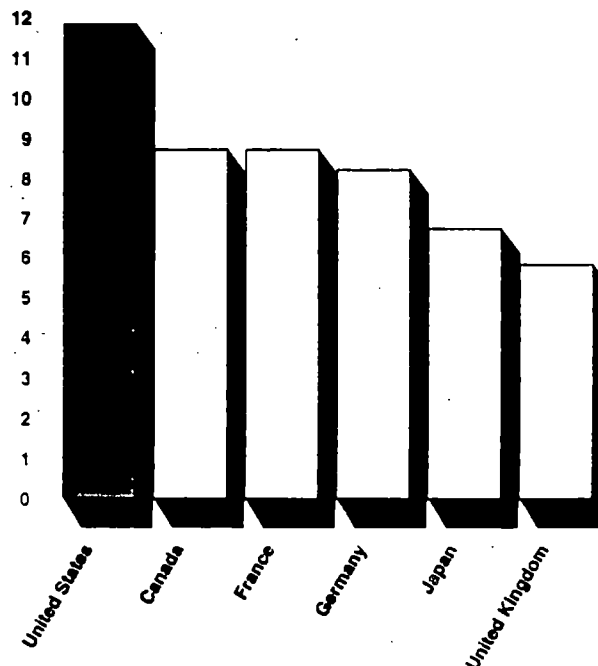


Figure 1.3: Health Care Spending as a
Share of Gross Domestic Product (1989)

Percent



Source: GAO/HRD-92-9. "Health Care Spending Control: The Experience of France, Germany and Japan," pp. 18-19.

ON SQUEEZING BALLOONS

Cost Control Fails Again

MEDICAL cost containment has been compared to squeezing a balloon — constraining one end causes the other end to bulge. The relentless rise in national health care expenditures — estimated to consume over \$700 billion and more than 12 percent of our gross national product in 1991 — has inspired numerous countermeasures. During the past two decades these have included creating incentives to join health maintenance organizations; utilization-review programs to curb unnecessary care; health planning constraints to prevent excess numbers of beds and unnecessary duplication of technology; price controls; malpractice reforms; coinsurance and deductibles to reduce patient demand; reductions in eligibility, benefits, and payment levels for those receiving Medicaid; limitations on reimbursement to hospitals through prospective payment; and most recently, the reform of physician payment through revised relative-value scales, the promulgation of clinical guidelines for the appropriateness of surgical procedures, and the resurgence of “managed care.” Common to each of these interventions has been a reductionist view of the causes behind rising expenditures for health care: fix one piece and the problem will go away. Although many of these programs have achieved desired effects on the piece of health care they were designed to change, the growth in national health care expenditures continues.

The report by Soumerai et al. in this issue of the *Journal* discusses yet another example of balloon squeezing. In this instance constraints were applied to the most vulnerable patients — that is, to those with both low incomes and complex illnesses — and the effects were particularly disturbing.¹ The authors report an experiment by the New Hampshire Medicaid program that placed a limit of three per month on the number of reimbursable drugs for patients living in the community. Although drug use decreased by 35 percent, an unfortunate and unintended result was an immediate twofold increase in nursing home admis-

sions. Whether the higher rates of admission resulted from declines in health status caused by the discontinuation of clinically appropriate drugs or a change in the behavior of patients and their families seeking to circumvent the community-based payment limits was unclear. The New Hampshire Medicaid policy was intended to reduce costs, but instead it led to the transfer of a large number of patients to an inappropriate setting and probably to greatly increased costs for the system as a whole. In short, the policy was penny wise and pound foolish.

The experience of the New Hampshire Medicaid program clearly demonstrates the limits of narrow approaches to containing health care costs. More carefully developed approaches, such as the Medicare prospective payment system for hospital care or elaborate utilization-review programs, are also likely to have unintended consequences. First, resourceful health care providers can often find offsetting cost-increasing responses to bypass narrow cost-containment tactics. Second, although piecemeal efforts at cost containment may accomplish their narrow goals, this achievement may come at the considerable price of diminished access, decreased quality, or excessively intrusive (and even expensive) bureaucracy.

The results of the New Hampshire limit on drug payments may be an extreme example, but its lesson can be applied to other efforts to contain health care costs. Over time, these efforts have become technically complex, spawning highly specialized bureaucracies and intruding ever more into the daily fabric of clinical decision making. In fact, it has been argued that such cost-containment efforts are partly responsible for the large proportion of our health care dollars that are now consumed by administrative expenses.² True, some cost-containment efforts have achieved savings of the first order. For example, studies of utilization review suggest that preadmission certification and review of continued stay have reduced the rates of hospital admission, length of stay, and expenditures.³ But at the same time there have been offsetting increases in the use of other health care services, such as ambulatory care. Squeeze the balloon in one place and it bulges somewhere else.

Does this mean that the United States should abandon its efforts to contain medical costs? This argument would be more persuasive if our national ranking in health status were as robust as our international position as number one in health care spending, and if there were not such persuasive evidence that commonly used procedures are performed too frequently.^{4,5} Indeed, money needlessly spent on health care is money forgone for other important social goods, such as education, housing, and the environment. And it is the perception of runaway health care costs that forestalls attention to such shameful national problems as the 34 million people who currently lack health insurance.

It makes intuitive sense that a service as complicat-

ed as health care should require a multisystem approach to cost containment. An effective cost-containment strategy would simultaneously attack patient demand for services, the pricing of hospital and medical care, medical malpractice, the appropriateness of expensive procedures (costly because of price, volume, or both), incentives to providers, and the supply and distribution of physicians and technology. Surely even the most resilient balloon would be deflated by such an approach. But the United States has never been willing to make such a frontal assault on medical costs. The political forces that confront those wrestling with the problem of ever-rising health care costs consist of competing special-interest groups representing the health care industry and its workers, business, labor, and various consumer groups, each of which is convinced that cost control should begin somewhere else.

Would system-wide strategies of cost containment be effective? Other developed countries, with unified systems to oversee health care financing and the production and distribution of physicians, have achieved better cost control.⁶⁻⁸ In the United States, two relatively limited efforts that addressed only the financing component of the health care system seemed to achieve overall cost savings. First, several states adopted all-payer systems to regulate hospital rates in the 1970s. The increases in health care costs in those states were more moderate than in others.⁹ The all-payer approach has the further advantage of ensuring special protection for the poor and uninsured, which can help avert some of the problems of diminished access that often accompany efforts at cost containment. Second, the most comprehensive cost-containment effort ever undertaken in this country was part of the Nixon administration's Economic Stabilization Program between 1972 and 1974. The program froze wages and prices throughout the economy, including the hospital industry. Inflation in the hospital industry slowed dramatically during this period, although it resumed its usual pattern after the freeze was lifted.

Perhaps the most important lesson from the New Hampshire experiment is that although the poor are a tempting political target for cost-containment efforts, those who seek a quick and politically painless solution may be deceiving themselves, as well as harming others. Some day, perhaps sooner than we think, there will be sufficient political momentum toward comprehensive cost containment to compel the involved parties to sacrifice some of their perceived self-interest in order to effect a reasonable solution. Until that day, the search for simple solutions will yield predictable results — more balloon squeezing. The least we can ask is that the squeezing be confined to balloons, not needy patients.

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The Importance of Relating Medicine and Public Health

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ABSTRACT: KEY INDEXING TERMS: [Am J Med Sci 1992; 303(6):000-000.]

A central premise of this year's Institute of Medicine annual meeting is that the historical division between medicine and public health is arbitrary and not necessarily in the best interests of the health of Americans. The break between medicine and public health occurred in the early part of this century when the Rockefeller Foundation decided to create schools of public health that were separate from schools of medicine.¹ Until that time, the distinction between attention to individual patients—now seen as the province of medicine—and attention to populations—the presumed arena of public health—was less clear. More recently, this split has been reinforced by the asymmetric hypertrophy of the medical care ventricle, stretched by public funding for patient care and by rapid medical technology development, compared to the hypoplastic public health chamber. Yet, as this analogy implies, I believe both medical care and public health are the heart of our nation's health care system and, for the patient to be healthy, we need both parts pumping effectively.

As a nation, the United States will spend more than 12% of its gross national product and more than \$700

billion on health care in 1991. If we had the luxury of taking all these resources and redeploying them to achieve the best possible health outcomes for our population, what kind of system would we create? Would it be what we have now?

Any sensible manager designing a system to affect health care outcomes would start by trying to understand the problem. One way to understand it is to examine national patterns of morbidity and mortality. Table 1 lists the nation's 11 leading causes of death, with years of potential life lost. For every one of these causes, a reduction in premature mortality cannot be achieved without attention to approaches found in both medicine and public health. For example, heart disease, the leading cause of death and the second leading cause of premature demise, already has declined impressively in recent decades. Using age-adjusted rates, heart disease death rates declined from 254 per 100,000 population in 1970 to only 150 in 1990.³ These improvements reflect: (1) advances in the treatment of heart disease—the medical model; (2) important changes in the prevalence of smoking and the intake of saturated fats—the public health model; and (3) dramatic strides in high blood pressure control, which have come from an effective combination of personal health services and public health programs, including education and screening. If improvements in heart disease mortality are to continue, and if similar progress is to occur for other diseases, we will continue to need both medicine and public health.

"Wait a minute!" you might say. "What's wrong with our current system?" Admittedly, the country invests more in treatment and research relating to the medical model than for public health. However, that investment has paid off, for heart disease to be sure and with impressive declines in deaths from other causes as well. Certainly, you may say, the hope for solving the AIDS problem lies in developing a vaccine, a prospect that seems much more likely today than it did 6 years ago, when AIDS was the theme of this annual meeting. Furthermore, the new age of molecular biology puts us on the threshold of even more impressive gains. "So," your argument might go, "the system ain't broke, so let's not try to fix it."

My response is that, as important as medicine is to improving the health of individuals, it is not sufficient

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The views expressed in this article are those of the author, and no official endorsement by The Robert Wood Johnson Foundation is intended or should be inferred.

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Relating Medicine and Public Health

Table 1. Eleven Leading Causes of Death and Years of Potential Life Lost, United States

Cause of Death	Rate,* 1990	Years of Potential Life Lost, 1989
Diseases of heart	289.0	3,619,749
Cancer	201.7	4,397,072
Cerebrovascular disease	57.9	578,439
Accidents	37.3	2,951,038
Chronic lung disease	35.5	435,517
Pneumonia and influenza	31.3	306,938
Diabetes mellitus	19.5	335,479
Suicide	12.3	972,512
Homicide	10.2	968,957
Chronic liver disease and cirrhosis	10.2	419,630
HIV infection	9.6	776,158

* Rate per 100,000 population.

National Center for Health Statistics and U.S. Bureau of the Census.

From reference 2.

to bring about the desired improvements in health outcomes. Let's look in more depth at "years of potential life lost." Table 2 shows for the nine leading causes of death the estimated proportions attributable just to substance abuse.

For cancer, the most important cause of premature death, one third of deaths are attributable to smoking and alcohol. For heart disease, suicide, and stroke, the proportion is about one quarter. For injuries, homicide, AIDS, and chronic lung diseases, substance abuse accounts for at least half of the fatalities. Clearly, the best strategy for reducing premature mortality would combine traditional medical interventions that focus on individual patients with population-focused strategies that discourage harm from the use of dangerous substances. That notion of discouraging harm, you may recognize, is one of The Robert Wood Johnson Foundation's new program goals.

For many other parameters, as well, health statistics show the United States as ranking below other developed countries. Certainly, a major reason our statistics are not better is the extreme gap between rich and poor citizens. However, we cannot ignore that for many of the countries whose statistics we envy, public health measures are seen as important national health strategies. Tough drunk driving laws, gun control, or contraception and sex education to prevent teenage pregnancies are all public health strategies other countries use effectively. Yet, we seem to lack the will to intervene with population-focused and preventive measures as effectively as we do with measures focused on treatment of individual patients.

An important exception is our response to cigarette smoking. Indeed, smoking trends in North America are better than those in Western Europe. But the progress in cigarette smoking has come about largely from spontaneous citizen action, supported by the remarkable leadership of our nation's Surgeons General, from

Table 2. Substance Abuse and Preventable Premature Mortality

Cause of Death	Years of Potential Life Lost, 1989	Percent Deaths Attributed to Substance Abuse
Cancer	4,397,072	32
Heart disease	3,619,749	20
Accidents and trauma	2,951,038	47
Suicide	972,512	28
Homicide	968,957	46
HIV infection	776,957	>50(?)
Cerebrovascular disease	578,439	25
Chronic lung disease	435,517	76
Liver disease and cirrhosis	419,630	>68

From reference 4.

Luther Terry to Julius Richmond to C. Everett Koop, three men who did have the will to promote public health strategies. Indeed, their leadership was blunted by our government's continued subsidy of the tobacco-growing and exporting industry.

To take another example, merely developing an HIV vaccine, as challenging and important as that will be, will not suffice to end the HIV epidemic. After all, we already have an excellent vaccine for measles, yet the numbers of measles cases (Table 3) have increased almost 20-fold in just 2 decades (Centers for Disease Control, Division of Immunization, Center for Prevention Services, Atlanta, GA, unpublished data).

That increase did not occur because the vaccine became ineffective. Rather, the cause is systematic underinvestment in the public health infrastructure needed to distribute the vaccine to susceptible children. Likewise, we know how to treat syphilis, and the treatment is excellent, yet the number of syphilis cases has doubled since 1970.

A successful approach to HIV, syphilis, and the other diseases we have touched upon must focus on populations as well as on individual patients. The failure to do this is what differentiates us from other developed nations. This explains why, although the United States spends more on health care than any other country, our health indices, such as infant mortality and life expectancy, consistently lag behind those of our economic peers. Put simply, our system does not provide adequate value for the money.

Table 3. The Retreat of Infectious Disease Control

Disease	Number of Cases	
	1970	1990
Measles	1,497	27,786
Syphilis	64,621	134,225

From reference 5.

Table 4. Problems with the U.S. Medical Care System

- Access
- Health status
- Overuse of expensive technologies
- Physician discontent
- Excess specialist-generalist physician ratio

The problems of our medical care system, some of which are listed in Table 4, are well known to you and get to the question of value for money spent.

First is the familiar but still shameful fact that more than 31 million people are without any health insurance coverage and that an additional 70 million or so have inadequate coverage. Even for people with public or private insurance, access to appropriate health care may be far from assured, including access to the kinds of basic services we classify as public health.

Next is our relatively poor health status compared to people in those countries that we consider social and economic peers.

Third is the overuse of costly medical technologies. A prime reason we spend so much more on medical care than do other countries is that we perform so many costly operations and procedures, such as coronary bypass surgery or magnetic resonance imaging. To be sure, the appropriate use of such procedures is one of the glories of our system. However, we probably perform from 20-50% more of them than is needed, with predictable increased expenditures.

Fourth is the pervasive unhappiness among practicing physicians. I was shocked to learn that 44% of physicians over age 40, and 35% of those under 40, regret having become physicians, according to surveys by the AMA and The Robert Wood Johnson Foundation.^{6,7} In comparison, only 15% of practicing lawyers are so disaffected. The reasons for this widespread discontent are complicated, but the evidence suggests that doctors' feelings that they lack control over their daily practice is an important factor. Much of this erosion of control has come from various third parties' futile but intrusive attempts at limiting medical expenditures. It's a paradox that the "least regulated" medical care system in the world imposes the most constraints on doctor's decisions in daily practice.

The final item in Table 4 refers to the nation's medical manpower policy, if we even have an explicit one, and its failure to produce physicians in the specialty or geographic distribution needed to meet the nation's needs. Our geographic maldistribution, which over-concentrates physicians in desirable urban and suburban communities while skimping on rural and inner city areas, parallels the situation in many other countries, even those with the most planned economies.

The United States does stand out, however, in its reliance on specialist physicians to give generalist care. In most other countries, 50-70% of physicians are gen-

eralists. In the United States, only about 30% are generalists.⁸ As shown in Table 5, that number inevitably will decline, because students are no longer as interested in becoming generalists.

The implications of a specialty-dominated medical care system for the issues of access, costs, and quality of medical care are clear. I also believe that the farther down the road we travel toward specialty domination, the more difficult the reunion between medicine and public health will be. Generalists, too, can be faulted for making this marriage rocky, but at least they are trained to take a broad view of patients' health, not just their diseases, and to see health in the context of the family and social environment. It is therefore a much more natural reunion for generalists.

To me, it is clear that if we could redesign our health care system from scratch, we would inevitably promote much closer integration of medicine and public health. Ironically, recent and current leaders at the Rockefeller Foundation—Kerr White and John Evans are two examples—now look for ways to "heal the schism," in White's words, between the two fields.¹

But there is a fundamental reason why this will be more difficult for the United States than it would be for almost any other nation. In this country, public health, compared to medical care, is associated with government, and our citizenry does not seem to trust or even respect its government. Remember that in recent times three successful politicians from different parties and very different viewpoints—George Wallace, Jimmy Carter, and Ronald Reagan—ran for the nation's highest office on the platform that government is the enemy from which they would protect the people. Many congressmen and state and local officials have done the same. In no other nation is the public health enterprise saddled with representing unpopular government, government for which the public is reluctant to pay. In fact, this reaction is so strong and so reflexive that even a public program that would have brought potentially great benefits—the Medicare catastrophic legislation—was defeated by the very people it would have helped.

Still, I find it easier to argue for closing the schism between medicine and public health than to describe effective means to do so. Perhaps that reflects my own perspective as an internist, internal medicine being a

Table 5. Specialty Preferences of Graduating Seniors, 1981, 1989, 1991

Specialty	1982 1981	1991 1989	% Change
Family/general practice	18.2 ±7.3%	10.5 ±8.7%	-20.8 - 42.3
General internal medicine	13.9 ±2.7	2.1 ±8.8	-58.3 - 84.9
General pediatrics	6.8 ±8.8	1.9 ±4.4	-27.3 - 72.1
% of all respondents	38.9 ±28.8	14.5 ±25.4	-34.5 - 62.7

From reference 9.

discipline historically preoccupied with diagnosis. But I think it is more a realization of how deep the schism runs, affecting the way services are organized and paid for with greatly different status accorded to the different parts of the system.

Perhaps the most important barrier to integration is the current system's fragmentation, which results from a lack of central coordination. Some special interests have used this as an opportunity to focus government's attention on isolated issues, further splintering the system. Meanwhile, groups that have difficulty mobilizing, such as children, the poor, or drug users, cannot attract sufficient resources for their health needs. Not surprisingly, this combination of powerful special interests and fragmented governmental health efforts has precluded a comprehensive approach to such fundamental problems as controlling health care expenditures.

The integration of medicine and public health to improve the health of the public must start at the top, with the federal government and with our nation's academic leadership. Although many others have a role, and although I will concentrate my remarks on these two critical sectors, I would like to underscore that leadership is needed from all quarters, to help citizens look beyond their own personal preoccupations and ideologies toward the greater social benefit offered by public health.

Currently, the executive branch health agencies and the congressional health committees are organized too strictly along categorical functions. This leads to such contradictions as we see in health manpower policy, where one federal agency advocates that the country would be better served if we had more generalist and fewer specialist physicians, while another agency pays doctors with incentives that favor specialization at the expense of generalism and is content to support residency training that produces the very specialty mixture it wishes to change.

Assistant Secretary for Health Jim Mason published a document that sets out an ambitious plan for better health for the public, "Healthy People 2000."¹⁰ The numerous goals set forth in that document can be achieved only through active, even enforced, integration of medicine and public health. However, the blueprint for such integration is still missing.

Integration also must occur within academia, between schools and faculties and research units in medicine and in public health. Academic health science centers are publicly supported because they provide certain socially useful functions, including the generation of new knowledge, the training of health professionals, and patient care. In return, they receive rather generous tax-generated dollars and operate under considerable autonomy. A recent grants program sponsored by The Pew Charitable Trusts and the Rockefeller Foundation called "Health of the Public: an Academic Challenge" advocates a set of goals and

principles for academic health centers (Table 6). To date, the program has funded 17 academic health science centers to adopt a broad, population-based construct of health that includes a number of academic objectives. These goals are based on the simple premise that academic health science centers have a social contract to improve the health of the public. They include:

- providing basic population-based competence for all health professional students;
- providing enhanced population-based skills for selected students, so those interested in public health careers can have appropriate training;
- integrating clinical prevention into all levels of health professional education, rather than leaving it to a separate, nonclinical academic unit;
- performing scholarly studies in fields related to population medicine, in other words, expanding the scholarly paradigm to include public health;
- assuming institutional responsibility for maximizing the health of a defined population—to do this an academic center must identify a community, monitor its health status, and direct resources to improving the population's health;
- involving the academic health center in decisions about resource allocation at the local, state, and national levels; and
- becoming an advocate for the health of the public.

Achieving these objectives will not be easy, but participating centers agree that each goal is essential. If this program is successful, it will constitute an important step toward integrating academic medicine and public health. By concentrating on the health challenges of a specific community, academic centers can demonstrate their concern for the health of a specific population, bring to bear analytic strength on a common problem, and demonstrate the value of such activities to students. The dynamics of this intervention will be different for the academic health centers in the program that include schools of public health.

Table 6. Objectives of Health of the Public—
an Academic Challenge*

-
- Provide basic competencies in population-based subjects to all health professional students
 - Provide enhanced population-based education for selected students
 - Include clinical prevention knowledge activities at all levels of health professional education
 - Conduct scholarly studies in population medicine
 - Assume institutional responsibility for maximizing the health of a defined population with available resources
 - Involve the academic health center in decision making about the development and deployment of health resources
 - Involve the academic health center in the social/political process as an advocate of the health of the public
-

* Sponsored by the Pew Charitable Trusts and The Rockefeller Foundation.

From reference 11.

Schroeder

In general, for the nation's 126 medical schools, better integration of public health principles means expanding the traditionally narrow definition of medicine, and the thinking about what is the proper domain of medicine, to include attention to the "health" themes covered here. In most schools, the responsibility for teaching and scholarship in these areas has been vested in what Kerr White calls "Departments of Miscellaneous Medicine." You know these as departments of preventive, or social, or community, or environmental medicine, singly or in some combination. In almost every instance, these departments are poorly endowed and have low status. Were each clinical department to reflect the critical public health dimensions of its field, such as the epidemiology and prevention of trauma for general surgery or the reduction of low birthweight for obstetrics and pediatrics, physicians might have a stronger sense of the importance of public health measures to their individual patients.

Earlier, I may have sounded pessimistic about prospects for unification of medicine and public health. The Institute of Medicine's 1988 report, "The Future of Public Health," called the relationship between medicine and public health "uneasy," but underscored how vital each is to the other.¹² To a certain degree, those who focus on individual patients and those who concentrate on populations will always have distinct approaches. That separation is now too great. It should be more "easy."

Every day, as president of The Robert Wood Johnson Foundation, I see proposals and projects that are trying to bridge this gulf, projects that offer some basis for hope that improved relationships are possible. Perhaps for that reason I am less pessimistic today. Progress can occur if we keep bringing the focus back to the most fundamental goal of professionals in both fields—improving the health of the American people.

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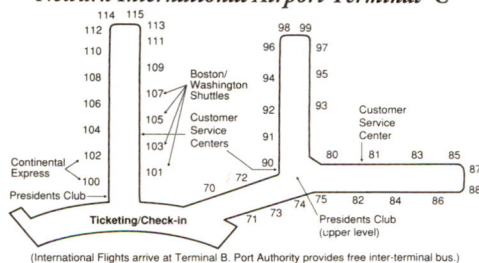
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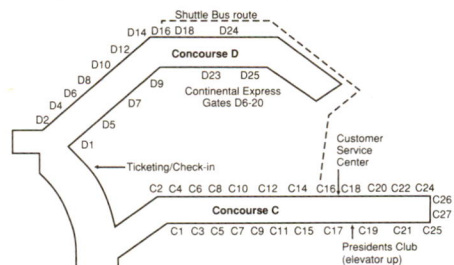
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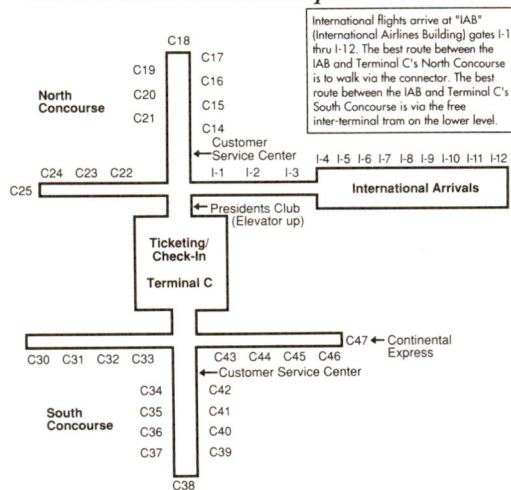
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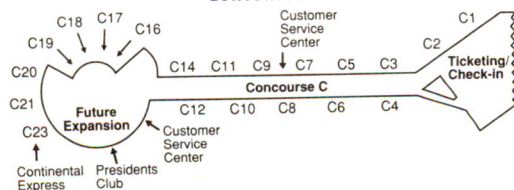
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714-751-0250	St. Louis	800-525-0280	St. Paul
MONTANA		VERMONT	
303-925-4350	Billings	800-525-0280	Burlington
714-923-7580	Bozeman	800-525-0280	Northfield
NEBRASKA		WASHINGTON	
303-398-3500	Nebraska	206-621-1740	Seattle
800-525-0280	Omaha	800-525-0280	Seattle
303-241-4200	Omaha	800-525-0280	Seattle
NEVADA		WISCONSIN	
800-525-0280	Las Vegas	800-525-0280	Madison
NEW HAMPSHIRE		WYOMING	
800-525-0280	Manchester	800-525-0280	Cheyenne
NEW JERSEY		YONKING	
800-525-0280	Newark	800-525-0280	Yonkers
800-549-5673	Newark	800-525-0280	Yonkers
NEW MEXICO		ALABAMA	
800-525-0280	Albuquerque	205-842-8220	Shelton
NEW YORK		IN THESE COUNTRIES call	
800-525-0280	Albany	800-525-0280	Bahamas
800-525-0280	Binghamton	800-525-0280	Bahamas
305-525-4176	Elmira	800-525-0280	Bahamas
813-939-2524	Elmira	800-525-0280	Bahamas
904-354-3543	Florida	800-525-0280	Bahamas
800-525-1400	New York	800-525-0280	Bahamas
407-295-6000	New York	800-525-0280	Bahamas
800-525-0280	St. Louis	800-525-0280	Bahamas
819-551-6680	St. Louis	800-525-0280	Bahamas
813-874-7120	St. Louis	800-525-0280	Bahamas
NORTH CAROLINA		FRANCE	
800-525-0280	Charlotte	1-42321-81	Paris
NORTH DAKOTA		GERMANY	
800-525-0280	Bismarck	069-757-4275	Frankfurt
404-456-3300	Bismarck	3-921-1631	Tokyo
OHIO		JAPAN	
800-525-0280	Akron	800-525-0280	Akron
800-525-0280	Cleveland	800-525-0280	Cleveland
312-686-6500	Cleveland	800-525-0280	Cleveland
800-525-0280	Columbus	800-525-0280	Columbus
800-525-0280	Columbus	800-525-0280	Columbus
800-525-0280	Columbus	800-525-0280	Columbus
OKLAHOMA		NEW ZEALAND	
316-263-9101	Oklahoma City	975-680	Auckland
OREGON		PHILIPPINES	
800-525-0280	Portland	800-525-0280	Manila
PENNSYLVANIA		SPAIN	
800-525-0280	Pittsburgh	800-525-0280	Madrid
800-525-0280	Pittsburgh	800-525-0280	Madrid
800-525-0280	Pittsburgh	800-525-0280	Madrid
RHODE ISLAND		UNITED KINGDOM	
800-525-0280	Providence	800-525-0280	London
800-525-0280	Providence	800-525-0280	London
800-525-0280	Providence		

Reservations and Information

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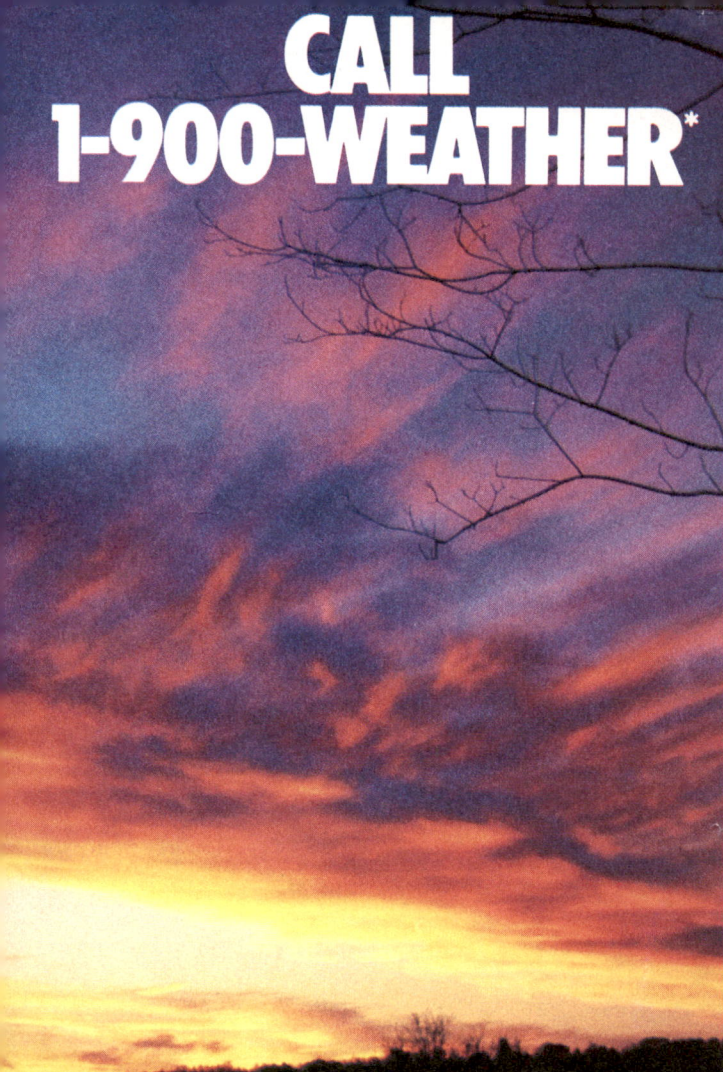
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Airlines®**

**Authorized
Travel Agent**

**WORLDWIDE WEATHER
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Ticket for:

BAGGAGE INFORMATION: 1. LOCK YOUR BAGGAGE. 2. CHECKED BAGGAGE MUST HAVE THE PASSENGER'S NAME ON THE OUTSIDE. 3. AMERICAN IS NOT RESPONSIBLE FOR CAMERA EQUIPMENT, JEWELRY, CASH OR OTHER SIMILAR VALUABLE ITEMS CONTAINED IN CHECKED OR UNCHECKED BAGGAGE. THESE ITEMS, AS WELL AS MEDICATIONS OR PRESCRIPTIONS, SHOULD BE CARRIED PERSONALLY BY YOU. 4. OUR LIABILITY FOR LOSS, DAMAGE OR DELAYS IS LIMITED TO \$1,250 PER PASSENGER DOMESTICALLY AND \$640.00 PER PIECE OF CHECKED BAGGAGE FOR INTERNATIONAL TRAVEL. THESE LIMITS WILL APPLY UNLESS AN EXCESS VALUATION IS DECLARED AT THE TIME OF CHECK-IN. 5. Fragile or perishable articles will be checked only at your own risk. 6. Baggage is designed to protect the contents. Scratches, nicks or dirt may appear despite care in handling. American does not assume liability for normal wear and tear to baggage.

CARRY-ON BAGGAGE: Each passenger may carry a maximum of two pieces of hand luggage, which must fit in an overhead compartment or under a seat. A briefcase is considered one of the allotted pieces, as are garment bags. Additionally, all baggage must be completely stowed before the airplane may depart the gate.

RESTRICTED ARTICLES: Acid, lighter fluid, matches and other items classified by the U.S. Government as hazardous materials—i.e., explosives, flammable solids and liquids, oxidizing materials, corrosive materials, compressed gasses, poisons, etiologic agents, radioactive materials and irritating materials cannot be carried in checked baggage. U.S. Government regulations require that firearms in checked baggage must be declared. Firearms must be presented in a hard case or a crushproof-type container manufactured specifically for shipment.

NOTICE-OVERBOOKING OF FLIGHTS

Airline flights may be overbooked, and there is a slight chance that a seat will not be available on a flight for which a person has a confirmed reservation. If the flight is overbooked, no one will be denied a seat until airline personnel first ask for volunteers willing to give up their reservation in exchange for a payment of the airline's choosing. If there are not enough volunteers, the airline will deny boarding to other persons in accordance with its particular boarding priority. With few exceptions, persons denied boarding involuntarily are entitled to compensation. However, to receive compensation, a passenger must present himself at the loading gate for boarding at least 10 minutes before scheduled departure. The complete rules for the payment of compensation and each airline's boarding priorities are available at all airport ticket counters and boarding locations.



THIS MORNING'S JOURNAL



THIS MINUTE'S JOURNAL

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B-22	L-53	V-83
C-23	M-61	W-91
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E-32	O-63	Y-93
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G-41	Q-01	+11
H-42	R-72	-13
I-43	S-73	* Enter
J-51	T-81	# Cancel

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PASSENGER TICKET AND BAGGAGE CHECK
SUBJECT TO CONDITIONS OF CONTRACT
NOT TRANSFERABLE

VDQ

PASSENGER RECEIPT

020108

0021016

A75

BOARDING PASS

ISSUED BY
AMERICAN AIRLINES
NAME OF ISSUING AGENT
DIDION TVL

ARC FLIGHT COUPON

TOUR CODE

AGENT CODE

A49594403

US29APR92

FCI SERV CARR ID

0 0011/

NOT VALID BEFORE NOT VALID AFTER

ISSUING AGENT ID

LHFO*12

NAME OF PASSENGER
PORTER/RICHARD

X/O FROM

NOT VALID FOR

X/O TO

**TRANSPORTATION*

ENDORSEMENTS/RESTRICTIONS

REFUND/REISSUES SUBJECT TO USD 25 FEE

FP AGENT CHECK /PCWAS AA X/DFW AA PHX254.55Y26 254.

55 END

PNR/CARRIER CODE

QTIDYO/AA Y26

CARRIER FLIGHT

CLASS DATE

TIME

STATUS

NOT VALID BEFORE

NOT VALID AFTER

ISSUING AGENT ID

LHFO*12

ISSUING AGENT ID

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EQUIV. FARE PD.

STOCK CONTROL NO. TX 889 CK

23842381780

CPN

0 001 1381900829 5

DOCUMENT NUMBER

0 001 1381900829 5

ALLOW PCS WT UNCKD

NAME OF PASSENGER

PORTER/RICHARD

DCA

FROM

XDFW AA177 Y 03MAYY26

PHX AA1633 Y 03MAYY26

TO

PCS WT UNCKD

PCS WT UNCKD

PCS WT UNCKD

ISSUED BY **American Airlines**
PASSENGER TICKET AND BAGGAGE CHECK
PASSENGER AND BOARDING
COUPON AND PASS

NAME OF PASSENGER
PORTER/RICHARD

X/O FROM
CHICAGO OHARE

X/O TO
PHOENIX

AMERICAN
CARRIER FLIGHT CLASS DATE DEPARTURE TIME
AA 539 Y 3 MAY 820P

GATE SEAT SMOKING
17A NO

CPN AIRLINE FORM AND SERIAL NUMBER

001/44B

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BEFORE YOU START ON THIS TRIP, PLEASE NOTE THE FOLLOWING POINTS.
OBSERVING THEM PROMPTLY MIGHT HELP YOU AVOID UNNECESSARY

SALES PERSON: 35
CUSTOMER NBR: 019999

ITINERARY/INVOICE NO. 0024420
RUWDQP

DATE: 14 MAY 92
PAGE: 01

TO: PRINCETON UNIVERSITY
DEPARTMENT OF ECONOMICS
ATTN PROF ALAN BLINDER
ACCOUNT NO. 355-2001

FOR: PORTER/RICHARD

16 MAY 92 - SATURDAY

RAIL AMTRAK SERVICE
LV WASHINGTON
AR PRINCETON JCT
- AMTRAK CLUB

CONFIRMATION NUMBER
720A
947A

A3869932
TRAIN 170

18 MAY 92 - MONDAY

RAIL AMTRAK SERVICE
LV TRENTON
AR WASHINGTON
AMTRAK CLUB

CONFIRMATION NUMBER

A3869932
TRAIN OPEN

SERVICE IMMEDIATELY ABOVE NOT YET CONFIRMED

RAIL TICKET A37296366466

180.00

SUB TOTAL

180.00

TOTAL AMOUNT

180.00

PASSENGER TICKET AND BAGGAGE CHECK SUBJECT TO CONDITIONS CONTAINED IN THIS TICKET

CONJUNCTION TICKET(S)

See below for Airline
Form, Serial Number

(1072)
(12-88)

ENDORSEMENTS/RESTRICTIONS (CARBON)

AMTRAK-RAIL SERVICE-AMTRAK

ARC PASSENGER COUPON

DATE OF ISSUE

14 MAY 92

ORIGIN/DESTINATION

BOOKING REFERENCE

ISSUED IN EXCHANGE FOR

PASSENGER NAME

PORTER/R

NOT TRANSFERABLE

PERSONAL TRAVEL

PSGR CPN

PRINCETON NJ

NOT GOOD FOR PASSAGE

CARRIER

FLIGHT

CLASS

DATE

TIME

STATUS FARE BASIS/TKT. DESIGNATOR

NOT VALID BEFORE

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ALLOW

TO WASHINGTON

A3

170P 16MAY

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OK 1CLUB

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TO WASHINGTON

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FARE

FARE CALCULATION

EQUIV. FARE PD.

180.00 WAS/PJC/TRE/WAS

RR869932 RF

97.00 AC

83.00 1RIDER

TAX

1352

TAX

EXEMPT

TAX

FORM OF PAYMENT

TOTAL

AGTCHK

A/L-AGT. INFO.

180.00

COUPON NO.

0011/RP0035

554

7296366466 4

ORIGINAL ISSUE

5541

DK019999

INV0024420

14313297602

DO NOT MARK OR WRITE IN THE WHITE AREA ABOVE

DATE AND PLACE OF ISSUE
IT IS UNLAWFUL TO PURCHASE OR RESSELL THIS TICKET FROM ANY ENTITY OTHER THAN THE ISSUING CARRIER OR ITS AUTHORIZED AGENTS

ALIGN HERE

1072

(12-88)

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ADVICE TO INTERNATIONAL PASSENGERS ON LIMITATION OF LIABILITY

(3-85)
Passengers on a journey involving an ultimate destination or a stop in a country other than the country of origin are advised that the provisions of a treaty known as the Warsaw Convention may be applicable to the entire journey, including any portion entirely within the country of origin or destination. For such passengers on a journey to, from, or with an agreed stopping place in the United States of America, the Convention and special contracts of carriage embodied in applicable tariffs provide that the liability of certain carriers, parties to such special contracts, for death of or personal injury to passengers is limited in most cases to proven damages not to exceed U.S. \$75,000 per passenger, and that this liability up to such limit shall not depend on negligence on the part of the carrier. The limit of liability of U.S. \$75,000 above is inclusive of legal fees and costs except that in case of a claim brought in a state where provision is made for separate award of legal fees and costs, the

limit shall be the sum of U.S. \$58,000 exclusive of legal fees and costs. For such passengers traveling by a carrier not a party to such special contracts or on a journey not to, from, or having an agreed stopping place in the United States of America, liability of the carrier for death or personal injury to passengers is limited in most cases to approximately U.S. \$10,000 or U.S. \$20,000.

The names of carriers, parties to such special contracts, are available at all ticket offices of such carriers and may be examined on request. Additional protection can usually be obtained by purchasing insurance from a private company. Such insurance is not affected by any limitation of the carrier's liability under the Warsaw Convention or such special contracts of carriage. For further information please consult your airline or insurance company representative.

NOTICE OF BAGGAGE LIABILITY LIMITATIONS

REV 4-84
Liability for loss, delay, or damage to baggage is limited unless a higher value is declared in advance and additional charges are paid. For most international travel (including domestic portions of international journeys) the liability limit is approximately \$9.07 per pound for checked baggage and \$400 per passenger for unchecked baggage. For travel wholly between U.S. points federal rules

require any limit on an airline's baggage liability to be at least \$1250 per passenger. Excess valuation may be declared on certain types of articles. Some carriers assume no liability for fragile, valuable or perishable articles. Further information may be obtained from the carrier.

NOTICE

If the passenger's journey involves an ultimate destination or stop in a country other than the country of departure the Warsaw Convention may be applicable and the Convention governs and in most cases limits the liability of carriers for death or personal injury and in respect of loss of or damage to baggage. See also notices headed "Advice to International Passengers on Limitation of Liability" and "Notice of Baggage Liability Limitations".

CONDITIONS OF CONTRACT

1. As used in this contract "ticket" means this passenger ticket and baggage check, of which these conditions and the notices form part. "carriage" is equivalent to "transportation", "carrier" means all air carriers that carry or undertake to carry the passenger or his baggage hereunder or perform any other service incidental to such air carriage, "WARSAW CONVENTION" means the Convention for the Unification of Certain Rules Relating to International Carriage by Air signed at Warsaw, 12th October 1929, or that Convention as amended at The Hague, 28th September 1955, whichever may be applicable.

2. Carriage hereunder is subject to the rules and limitations relating to liability established by the Warsaw Convention unless such carriage is not "international carriage" as defined by that Convention.

3. To the extent not in conflict with the foregoing carriage and other services performed by each carrier are subject to: (I) provisions contained in this ticket, (II) applicable tariffs, (III) carrier's conditions of carriage and related regulations which are made part hereof (and are available on application at the offices of carrier), except in transportation between a place in the United States or Canada and any place outside thereof to which tariffs in force in those countries apply.

4. Carrier's name may be abbreviated in the ticket, the full name and its abbreviation being set forth in carrier's tariffs, conditions of carriage, regulations or timetables; carrier's address shall be the airport of departure shown opposite the first abbreviation of carrier's name in the ticket; the agreed stopping places are those places set forth in this ticket or as shown in carrier's timetables as scheduled stopping places on the passenger's route; carriage to be performed hereunder by several successive carriers is regarded as a single operation.

5. An air carrier issuing a ticket for carriage over the lines of another air carrier does so only as its agent.

CARRIER RESERVES THE RIGHT TO REFUSE CARRIAGE TO ANY PERSON WHO HAS ACQUIRED A TICKET IN VIOLATION OF APPLICABLE LAW OR CARRIER'S TARIFFS, RULES OR REGULATIONS
Issued by the Carrier whose name is in the "Issued By" section on the face of the Passenger Ticket and Baggage Check

SUBJECT TO TARIFF REGULATIONS

6. Any exclusion or limitation of liability of carrier shall apply to and be for the benefit of agents, servants and representatives of carrier and any person whose aircraft is used by carrier for carriage and its agents, servants and representatives.

7. Checked baggage will be delivered to bearer of the baggage check. In case of damage to baggage moving in international transportation complaint must be made in writing to carrier forthwith after discovery of damage and, at the latest, within 7 days from receipt; in case of delay, complaint must be made within 21 days from date the baggage was delivered. See tariffs or conditions of carriage regarding non-international transportation.

8. This ticket is good for carriage for one year from date of issue, except as otherwise provided in this ticket, in carrier's tariffs, conditions of carriage, or related regulations. The fare for carriage hereunder is subject to change prior to commencement of carriage. Carrier may refuse transportation if the applicable fare has not been paid.

9. Carrier undertakes to use its best efforts to carry the passenger and baggage with reasonable dispatch. Times shown in timetable or elsewhere are not guaranteed and form no part of this contract. Carrier may without notice substitute alternate carriers or aircraft, and may alter or omit stopping places shown on the ticket in case of necessity. Schedules are subject to change without notice. Carrier assumes no responsibility for making connections.

10. Passenger shall comply with Government travel requirements, present exit, entry and other required documents and arrive at airport by time fixed by carrier or, if no time is fixed, early enough to complete departure procedures.

11. No agent, servant or representative of carrier has authority to alter, modify or waive any provision of this contract.

REV. 3-59

A-538 PRINTED IN U.S.A. BY RAND McNALLY REV. 11-91

Passenger Ticket

Continental



005:4475:906:801

NOTICE-OVERBOOKING OF FLIGHTS

Airline flights may be overbooked, and there is a slight chance that a seat will not be available on a flight for which a person has a confirmed reservation. If the flight is overbooked, no one will be denied a seat until airline personnel first ask for volunteers willing to give up their reservation in exchange for a payment of the airline's choosing. If there are not enough volunteers, the airline will deny boarding to other persons in accordance with its particular boarding priority. With few exceptions, persons denied boarding involuntarily are entitled to compensation. The complete rules for the payment of compensation and each airline's boarding priorities are available at all airport ticket counters and boarding locations. *Some airlines do not apply these consumer protections to travel from some foreign countries, although other consumer protections may be available. Check with your airline or travel agent.*

ISSUED BY
ENDORSEMENTS

NAME OF PASSENGER

X/O FROM

TO

TO

TO

FARE

EQUIV. FARE PD.

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TAX

TOTAL

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A-538

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and TicketChek

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REV. 11-91

REV. 2-83A

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ISSUED BY
Continental

PASSENGER TICKET AND BAGGAGE CHECK
SUBJECT TO CONDITIONS
OF CONTRACT ON
PASSENGER'S COUPON

ORIGIN/DESTINATION
BOOKING REFERENCE
ISSUED IN EXCHANGE FOR

AIRLINE
FORM
SERIAL NUMBER
005:4475:906:801
22 CONTINENTAL
HOUSTON/IAH
LJ 041202 2105
041216

ENDORSEMENTS (CARBON)
RECEIVED ONLY NON REF
NC A TH E 2145 P 49
CHANGES OK V CLASS ONLY

PASSENGER'S COUPON
DATE OF ISSUE
29 JUL 92

NAME OF PASSENGER
WINTER RICHARD
NOT TRANSFERABLE

TOUR CODE

CONJUNCTION TICKET(S)

DATE AND PLACE OF ISSUE
92

X/O	NOT GOOD FOR PASSAGE	CARRIER	FLIGHT	CLASS	DATE	TIME	STATUS	FARE BASIS/TKT. DESIGNATOR	NOT VALID BEFORE	NOT VALID AFTER	ALLOW
FROM	WASHINGTON/NATL	CO	1124	V	14AUG	624P	OK	RR03E		14AUG	
TO	HOUSTON/IAH				VOID						
TO	VOID				VOID						
TO	VOID				VOID						
TO	VOID				VOID						

FARE	129.09	14AUG92	DCA	CO	HOU	129.09	ARR	129.09
EQUIV. FARE PD.	TTL 129.09 END							
TAX	US 12.91							
TAX								
TAX								
TOTAL	142.00							
	0321 1215							

CPN

TICKET NUMBER

CK

FORM OF PAYMENT
CHECK

ORIGINAL ISSUE

DO NOT MARK OR STAMP IN THE WHITE AREA ABOVE

IT IS UNLAWFUL TO PURCHASE OR RESELL THIS TICKET FROM TO ANY ENTITY OTHER THAN CONTINENTAL AIRLINES, INC. OR ITS AUTHORIZED AGENTS

ADVICE TO INTERNATIONAL PASSENGERS ON LIMITATION OF LIABILITY

Passengers on a journey involving an ultimate destination or a stop in a country other than the country of origin are advised that the Warsaw Convention may be applicable to the entire journey, including any portion entirely within the United States of America, or destination. For such passengers on a journey to, from, or with an agreed stopping place in the United States of America, and special contracts of carriage embodied in applicable tariffs provide that the liability of certain carriers, parties to such contracts, for death of or personal injury to passengers is limited in most cases to proven damages not to exceed U.S. \$20,000, and that this liability up to such limit shall not depend on negligence on the part of the carrier. The limit of liability of the carrier above is inclusive of legal fees and costs except that in case of a claim brought in a country where provision is made for separate legal fees and costs, the limit shall be the sum of U.S. \$58,000 exclusive of legal fees and costs. For such passengers traveling by air as a party to such special contracts or on a journey not to, from, or having an agreed stopping place in the United States of America, liability of the carrier for death or personal injury to passengers is limited in most cases to approximately U.S. \$10,000 or less. The names of carriers, parties to such special contracts, are available at all ticket offices of such carriers and may be examined by passengers. Additional protection can usually be obtained by purchasing insurance from a private company. Such insurance is not affected by the limitation of the carrier's liability under the Warsaw Convention or such special contracts of carriage. For further information contact your airline or insurance company representative.

NOTICE OF BAGGAGE LIABILITY LIMITATIONS

Loss, delay, or damage to baggage is limited as follows unless a higher value is declared in advance and additional charges are paid: (1) For most international travel (including domestic portions of international journeys) to approximately \$9.07 per pound (\$20.00 per kilo) for checked baggage and \$400 per passenger for unchecked baggage; (2) For travel wholly between U.S. points, to \$1250 per passenger on checked baggage (a few have lower limits). Excess valuation may not be declared on certain types of valuable articles. Carriers assume no liability for perishable articles. Further information may be obtained from the carrier.

NOTICE

If the passenger's journey involves an ultimate destination or stop in a country other than the country of departure the Warsaw Convention may be applicable and the Convention governs and in most cases limits the liability of carriers for death or personal injury and in respect of loss of or damage to baggage. See also notices headed "Advice to International Passengers on Limitation of Liability" and "Notice of Baggage Liability Limitations."

CONDITIONS OF CONTRACT

1. As used in this contract "ticket" means this passenger ticket and baggage check, of which these conditions and the notices form part, "carriage" is equivalent to "transportation", "carrier" means all air carriers that carry or undertake to carry the passenger or his baggage hereunder or perform any other service incidental to such air carriage, "WARSAW CONVENTION" means the Convention for the Unification of Certain Rules Relating to International Carriage by Air signed at Warsaw, 12th October 1929, or that Convention as amended at The Hague, 28th September 1955, whichever may be applicable.
2. Carriage hereunder is subject to the rules and limitations relating to liability established by the Warsaw Convention unless such carriage is not "international carriage" as defined by that Convention.
3. To the extent not in conflict with the foregoing carriage and other services performed by each carrier are subject to: (I) provisions contained in this ticket, (II) applicable tariffs, (III) carrier's conditions of carriage and related regulations which are made part hereof (and are available on application at the offices of carrier), except in transportation between a place in the United States or Canada and any place outside thereof to which tariffs in force in those countries apply.
4. Carrier's name may be abbreviated in the ticket, the full name and its abbreviation being set forth in carrier's tariffs, conditions of carriage, regulations or timetables; carrier's address shall be the airport of departure shown opposite the first abbreviation of carrier's name in the ticket; the agreed stopping places are those places set forth in this ticket or as shown in carrier's timetable as scheduled stopping places on the passenger's route; carriage to be performed hereunder by several successive carriers is regarded as a single operation.
5. An air carrier issuing a ticket for carriage over the lines of another air carrier does so only as its agent.

6. Any exclusion or limitation of liability of carrier shall apply to and be for the benefit of agents, servants and representatives of carrier and any person whose aircraft is used by carrier for carriage and its agents, servants and representatives.
7. Checked baggage will be delivered to the bearer of the baggage check. In case of damage to baggage moving in international transportation complaint must be made in writing to carrier forthwith after discovery of damage and, at the latest, within 7 days from receipt; in case of delay, complaint must be made within 21 days from date the baggage was delivered. See tariffs or conditions of carriage regarding non-international transportation.
8. This ticket is good for carriage for one year from date of issue, except as otherwise provided in this ticket, in carrier's tariffs, conditions of carriage, or related regulations. The fare for carriage hereunder is subject to change prior to commencement of carriage. Carrier may refuse transportation if the applicable fare has not been paid.
9. Carrier undertakes to use its best efforts to carry the passenger and baggage with reasonable dispatch. Times shown in timetable or elsewhere are not guaranteed. Carrier assumes no responsibility for making connections. Except to the extent provided in carrier's tariff, carrier shall not be liable for failing to operate any flight according to schedule or for changing the schedule of any flight provided that whenever practicable carrier will attempt to notify passenger of any schedule irregularity or change in advance of scheduled departure. Under no circumstances shall carrier be liable for consequential damages resulting from such schedule change or irregularities.
10. Passenger shall comply with Government travel requirements, present exit, entry and other required documents and arrive at airport by time fixed by carrier or, if no time is fixed, early enough to complete departure procedures.

CARRIER RESERVES THE RIGHT TO REFUSE CARRIAGE TO ANY PERSON WHO HAS ACQUIRED A TICKET IN VIOLATION OF APPLICABLE LAW OR CARRIER'S TARIFFS, RULES OR REGULATIONS

ISSUED BY CONTINENTAL AIRLINES, INC.

SOLD SUBJECT TO TARIFF REGULATIONS

Passengers of provisions of a treaty country of origin or the Convention and special contracts, \$75,000 per passenger U.S. \$75,000 above award of legal fees a carrier not a States of America U.S. \$20,000. The on request. Add any limitation of please consult y

Liability for loss paid: (1) For most for checked baggage most carriers (2) for fragile or per

NOTICE OF INCORPORATED TERMS OF CONTRACT OF CARRIAGE

Air transportation provided by Continental Airlines, Inc. between points in the U.S. (including its overseas territories and possessions) is subject to the following Conditions of Contract and the Conditions of Contract on the passenger's coupon not inconsistent herewith. Foreign air transportation is governed by applicable tariffs on file with the U.S. and other governments. **OTHER CARRIERS ON WHOM YOU MAY BE TICKETED MAY HAVE DIFFERENT CONDITIONS OF CARRIAGE.** You have the right to inspect the full text of each transporting air carrier's terms at its airport and city ticket offices. You also have the right, upon request, to receive free of charge from each of the transporting air carriers the full text of the applicable terms incorporated by reference. Information on ordering the full text of each carrier's terms is available at any U.S. location where the carrier's tickets are sold. Incorporated terms may include, but are not restricted to:

1. Limits on liability for personal injury or death.
2. Limits on liability for baggage, including fragile or perishable goods, and availability of excess valuation coverage.
3. Claims restrictions, including time periods in which passengers must file a claim or bring an action against the air carrier.
4. Rights of the air carriers to change the terms of the contract.
5. Rules on reconfirmation of reservations, cancellation of reservations, check-in times, and refusal to carry.
6. Rights of the carrier and limits on liability for delay or failure to perform service, including schedule changes, substitution of alternate air carriers or aircraft and routing.

Baggage claims against Continental Airlines, Inc. for loss or damage must be reported at a baggage service office within four hours after discovery of loss or damage. All baggage claims must be filed in writing to Continental within 45 days of the date of the occurrence. Continental reserves the right to collect a **SERVICE CHARGE** for the refund of tickets, for the purchase of tickets to be used at a later date ("Prepaid Tickets"), or for any reissue of tickets when done so at the passenger's request. Passengers with special or discount fare tickets who voluntarily change their reservations and/or itinerary are subject to being charged an **ADDITIONAL COLLECTION** for the difference between the fare shown on the ticket and the full fare. Certain special fare tickets may be non-refundable. Continental is not responsible for tickets lost by the passenger. Continental's full text may be obtained by writing to: Continental Airlines, Inc., Customer Relations, P.O. Box 4607, Houston, Texas 77210-4607.

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NOT FOR USE IN MAGNETIC STRIPE READERS

ADVICE TO INTERNATIONAL PASSENGERS ON LIMITATION OF LIABILITY

Passengers on a journey involving an ultimate destination or a stop in a country other than the country of origin are advised that the provisions of a treaty known as the Warsaw Convention may be applicable to the entire journey, including any portion entirely within the country of origin or destination. For such passengers on a journey to, from, or with an agreed stopping place in the United States of America, the Convention and special contracts of carriage embodied in applicable tariffs provide that the liability of certain carriers, parties to such special contracts, for death of or personal injury to passengers is limited in most cases to proven damages not to exceed U.S. \$75,000 per passenger, and that this liability up to such limit shall not depend on negligence on the part of the carrier. The limit of liability of U.S. \$75,000 above is inclusive of legal fees and costs except that in case of a claim brought in a state where provision is made for separate award of legal fees

and costs, the limit shall be the sum of U.S. \$58,000 exclusive of legal fees and costs. For such passengers traveling by a carrier not a party to such special contracts or on a journey not to, from, or having an agreed stopping place in the United States of America, liability of the carrier for death or personal injury to passengers is limited in most cases to approximately U.S. \$10,000 or U.S. \$20,000.

The names of carriers, parties to such special contracts, are available at all ticket offices of such carriers and may be examined on request. Additional protection can usually be obtained by purchasing insurance from a private company. Such insurance is not affected by any limitation of the carrier's liability under the Warsaw Convention or such special contracts of carriage. For further information please consult your airline or insurance company representative.

NOTICE OF BAGGAGE LIABILITY LIMITATIONS

Liability for loss, delay, or damage to baggage is limited unless a higher value is declared in advance and additional charges are paid. For most international travel (including domestic portions of international journeys) the liability limit is approximately \$9.07 per pound for checked baggage and \$400 per passenger for unchecked baggage. For travel

wholly between U.S. points federal rules require any limit on an airline's baggage liability to be at least \$1250 per passenger. Excess valuation may be declared on certain types of articles. Some carriers assume no liability for fragile, valuable or perishable articles. Further information may be obtained from the carrier.

Issued
By

Continental



PORTER/RICHARD

**TO
IAH**

**FLIGHT
1124
SEAT
A 10E**

* NOT VALID WITHOUT *
* FLIGHT COUPON ATTACHED *

Continental

ADVANCE BOARDING PASS



Name of Customer

PORTER/RICHARD

From

WASHINGTON

To

HOUSTON

Carrier	Flight	Class	Date	Departure Time
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C01124	Y	14AUG		
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Gate	Boarding Time	Seat	
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****		10E	NO
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**THANK YOU FOR CHOOSING
CONTINENTAL AIRLINES!**

Flight(s)	LC	V/S
1124		

Your baggage is checked to
Houston, TX
(see other side for terms)

Continental

92 47 53

Baggage accepted subject to Conditions of Contract (as carrier if Continental flights; only as agent if Continental Express flights) or tariffs including limitations of liability herein contained. This is not the luggage ticket (baggage check) described in Article 4 of the Warsaw Convention or the Warsaw Convention as amended by the Hague Protocol, 1955. Baggage claims against carrier on flight for loss or damage must be reported at a baggage service office within four hours after discovery of loss or damage. All baggage claims must be filed in writing to Continental within 45 days of the date of occurrence.

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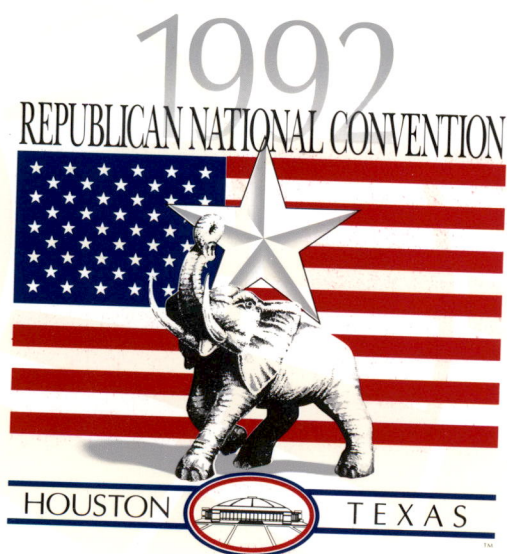
Group

GROUP NAME _____
NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE NUMBER _____
HOTEL _____
TRAVEL AGENCY _____
TRAVEL AGENCY PHONE NUMBER _____

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