

Originally Processed With FOIA(s):
2021-0094-F

FOIA Number:
2021-0094-F

FOIA MARKER

**This is not a textual record. This is used as an
administrative marker by the George Bush Presidential
Library Staff.**

Record Group/Collection: Dan Quayle Vice Presidential Records
Collection/Office of Origin: Deputy Chief of Staff's Office
Series: Porter, Richard W., Files
Subseries: Subject Files

OA/ID Number: 21807
Folder ID Number: 21807-033

Folder Title:
Health Plan [4]

Stack:	Row:	Section:	Shelf:	Position:
G	34	6	5	4

8-31-92 9/16

Headthcare

FYE

Richard:

On Vice President's convention speech
was terrific, really "let it out of the Park!"
I hope we get to hear more of him!

Best regards

Tom Gal

THE LAW OFFICES OF
DEBORAH STEELMAN
Columbia Square
555 13th Street, N.W. - Suite 1220 East
Washington, D.C. 20004-1109

(202) 637-5890
TELECOPIER: (202) 637-5892

TELECOPIER COVER SHEET

Date: 5/1/92 Time: 7:15

Fax No.: 456-6216 Client No.: 0001

To: Richard Porter

From: Deborah Steelman

Number of Pages (excluding cover sheet): 3

Person Sending: Chris Ehrlich

Other Instructions: _____

**IF YOU HAVE ANY PROBLEMS RECEIVING, PLEASE
CALL PERSON SENDING IMMEDIATELY**

Richard -

Martin is being pressured
by some of her staff to
file amicus on this. TERRIBLE
IDEA. Competitiveness Council should
weigh in. See last paragraph.
Please call me Monday.

Debbie



American Council of Life Insurance

March 27, 1992

Harris Trust v. John Hancock

- * The significance of this case is enormous. In 1990, the total reserves held by life insurance companies under group annuity contracts with pension plans was more than \$426 billion. Of this total, more than \$308 billion was held in general investment account reserves. More than 157,000 plans are covered by these contracts. (1991 Life Insurance Fact Book at 26).
- * The Labor Department's amicus brief necessarily will have policy implications far beyond its immediate impact upon the litigants in the Harris Trust case. Any comment made by the Department will be a public record and will be viewed as an official elaboration of its regulatory position.
- * The general account is an insurance company's principal asset and liability account with respect to most of its policies, both with employee benefit plans and with other policyholders. It is a commingled account.
 - * Insurers' general account policies contain a wide range of contract features, and those features frequently differ from insurer to insurer. The group annuity policy in the Harris Trust case, however, is a garden variety form of general account contract that was in broad general use in the insurance industry when ERISA was enacted. It is the kind of traditional insurance product that Congress intended to exempt from ERISA's fiduciary rules.
- * The general account is also an insurer's operating account.
 - * Its assets include the insurer's building, equipment, furniture, employment contracts, registered trademarks and service marks, operating licenses, and other operational assets, in addition to its stocks, bonds, real estate and other invested assets.
 - * From its general account, an insurer pays all of its operating expenses, such as salary, rent and taxes, and all of its obligations to creditors, in addition to its benefit obligations to its policyholders.
 - * The general account is also the source of dividend payments to policyholders and, in the case of stock insurers, dividends paid to shareholders.

* Under state insurance law, all of an insurer's general account assets are available to satisfy each of the insurer's obligations, with no assets being segregated to meet the insurer's obligations under any particular contract.

* If the views advocated by the plaintiff in the Harris Trust case were to be adopted, the management and operation of the general account of an insurer would be regulated under ERISA as well as under state insurance law. Those laws, however, impose inconsistent and irreconcilable legal standards. ERISA requires plan assets to be administered solely in the interest of and for the exclusive benefit of a single plan's participants; state insurance law requires that general accounts be administered fairly and equitably for all policyholders of the general account as a group, whether or not they are ERISA plans.

* The normal operation of an insurance company general account is inherently incompatible with ERISA's fiduciary rules. If those rules were held to apply to a contract of the kind at issue in the Harris Trust case, all management and investment decisions affecting the general account would be exposed to legal attack under ERISA. The irreconcilable conflict between ERISA's fiduciary rules and state law requirements would almost inevitably lead to a wave of litigation.

* For the last sixteen years, insurance companies have relied in good faith upon their understanding of ERISA's "guaranteed benefit policy" exception and the Labor Department's interpretation of ERISA contained in its 1975 Interpretative Bulletin, which was ratified and augmented by its 1986 plan asset regulation. Given the narrow scope of the Circuit Court's request and the fact that the John Hancock contract at issue in the Harris Trust case is indisputably the kind of contract that Congress considered to be a "guaranteed benefit policy," the Labor Department should affirm in its amicus brief that the assets held by John Hancock under the contract are not plan assets and that ERISA's fiduciary rules, therefore, do not apply. Because the Harris Trust case involves a conventional insurance product, the Department should not find it necessary to amplify or expand upon existing interpretations, nor should it feel compelled to do so in light of the small amount of time available to respond to the court's request.

* The industry strongly recommends that, unless the Department is able to limit its discussion to the contract at issue in the litigation, the Department should decline to file an amicus brief in the Harris Trust case, citing the need to develop additional policy through a regulatory process rather than by amicus brief. In the meantime, the Department can, and should, stand by its current regulations without further elaboration.

TALKING ABOUT HEALTH AND HEALTH CARE

1. People and experts fundamentally speak different languages regarding the causes of our health care system's dysfunctions.

A. What people talk about around their own kitchen tables:

- health care costs are a terrible problem
- so little time with doctor for so much
- such a little pill for so much
- employer making them pay more every year
- greed of doctors
- greed of lawyers
- fraud of hospitals (\$8 aspirin)
- ridiculous bureaucracy of insurers and Medicare
- people are freeloading on the system
- the care they just received was a miracle
- something has to be done
- mistrust of government

B. What people are not talking about around their own kitchen tables:

- that they use too much technology
- that they see their doctor too often
- that their own behaviors cause their illnesses
- that no care should be provided to their relatives or loved ones if doctors deem it futile
- that the miracles are worth the money
- what specifically should be done

2. People believe the main factors driving up costs are human factors such as greed, high salaries, corruption, waste, and unnecessary testing. People deny or reject the notions that costs are increasing because of the explosion of technology and the aging population, or that quality will be sacrificed if costs are reduced substantially. (Yankelovich, late 1991)
3. People want to make their own coverage more secure without changing what they have, sacrificing their current level of coverage, or increasing their current level of costs. People believe that their own sacrifice would be fruitless because any savings will be absorbed by the greed in the system. Until others in the system sacrifice (doctors, lawyers, hospitals, insurance) they see no use in their own sacrifice.

4. Now is the time for new thinking for ways to solve problems, not merely dusting off old proposals and talking about old problems. People want new thinking. There is nothing older than the concept of national health insurance, and play-or-pay is a take-off on a 20 year old Nixon plan. The more you listen to their real concerns and the more innovative you are in response to their concerns (as opposed to those you hear inside the beltway), the better you will be received.
5. The mix of problems known as cost and access will get worse. Health care expenses will continue to grow as a percent of family household expenses and GDP. Without action to address it, the number of uninsureds, particularly part-year uninsureds, will remain relatively stable. Demand will increase for long term care services and a better way to finance these expenses. Because of the complex nature of these and other issues, and the need to build public support to solve them, any successful political message must be derived from these elements:
 - A. Recognize the public's concern. We need major reform. Do not begin your address with platitudes about the best health care in the world or the need to "keep what is good" or that you favor an incremental approach.
 - B. Deal with the problem as people see it today. Address the waste issue: medical liability, abuse by self-referring physicians, administrative costs, and hospital fraud and mismanagement, etc. These are not "incremental approaches;" these attack the heart of what people believe are primary problems.
 - C. Educate your listeners. Addressing only the issues people now believe are the real problems -- greed and waste -- will not address what experts know is an unsustainable system, a system deliberately designed to conceal the relationships between cost, demography, behavior, medical practice, and technology. For example, almost 38% of Medicare's funding comes from general revenues, yet the program's design invites its beneficiaries to believe that they paid for the program themselves through the payroll tax. And the costs of high-tech medicine are hidden through insurance, particularly employer-sponsored insurance. Expose these factors that obscure our judgment about who is paying and for what, and the inherently inflationary system we have created through insulating ourselves from the consequences of our actions, both societal and individual.

- D. Listen to your constituents. They may say they want "Canada". Ask them why. They will then personalize their own situation and they will not describe Canada. The longer people talk about the issue, the more they turn away from the Canadian model or other forms of national health insurance and move toward embracing reform of the private market.
- E. Acknowledge that we must start now, but change in deeply set values takes time. Stretch your listeners' thinking by describing issues that are not currently a big part of the sound-bite debate. Our drug approval system limits access through the longest approval process and tighter restrictions on moving products to over-the-counter sales. This costs. We have the most violent society on earth. This costs. We have the highest expectations for immediate access to high-technology care. This costs. We do not ration most care. This costs. We have poor nutrition and fitness habits; we spend about \$180 billion for individuals addicted to alcohol and other substances. This costs. We take heroic measures to prolong the most doomed lives. This costs. We produce one of the highest incidence of low birth weight babies among civilized nations. This costs. Changing our values on these issues will not be quick or easy.

TALKING POINTS

There is no one size fits all message.

Attached are two sets of talking points, one focused on broadening the understanding of the issues, one focused more on raw politics. These talking points are directed toward a variety of promising policy directions, including:

- greater individual responsibility;
- reforming the private market, including tax credits, insurance reform, medical liability, antitrust laws, and practice guidelines;
- universal access to care now for all children under 12 through school area child health care centers and for all children and young adults under 25 through school-district voluntary health insurance;
- increased funding for community health centers, rural manpower and emergency services; and
- enhanced public education regarding health promotion and disease prevention.

These talking points do not include support for the following concepts:

- rate regulation through either all-payer or single-payer systems;
- any type of national commission to determine a national benefit package or set insurance or provider rates;
- tax-based universal health insurance; and
- the status quo.

TALKING POINTS, #1

1. The way we approach health and health care in this country must undergo major changes. Business as usual is unsustainable.
2. Millions of Americans do not have access to appropriate health care because of significant barriers in the delivery and financing of health care.
3. Health care costs too much. If health care expenditures grow at the same rate we have experienced over the last two decades, health care will consume 31.5 of our GNP in the year 2020, even if the GNP grows at an annual rate of 3.9 percent during the period, as assumed in the OASDI and Medicare Trustees Report.
4. This trend threatens the economy upon which the financial security of all Americans rests. In order to accommodate health care and income security needs, and at the same time support levels of consumer demand and a quality of life consistent with that enjoyed today by most Americans, we must increase the size of the economy and reduce health care costs.
5. This nation must dramatically reform our health care system. We are at crossroads. This year, we will decide what kind of major reform we want. Should we have a government controlled system, or should we make the private market work for people? Should we adopt the Democrats' play-or-pay plan that puts jobs at risk, and raises billions in taxes, and will lower the quality of health care for millions? Or should we reform the private market, restore common sense to the insurance market, get lawyers out of the way, and allow people to take more control over their own health care decisions?
6. We need major changes but we can't snap our fingers to get there. It will take all of us working together. I need your help.
7. No other country will give us the magic answer -- not in 1776, not in 1941, not today.
8. We shouldn't adopt changes that are worse than the status quo. We don't want a cure worse than the disease.
9. We need to address basic issues, not just changing the way we finance health insurance. The Democrats believe that simply giving everyone a plastic card and asking us all to pay extra taxes will do the trick. It won't work. We have to address the actions of individuals that cause so many unnecessary health care costs.

10. A taxpayer-financed plastic card won't eliminate AIDS (medical costs estimated to be \$5-13 billion by 1992), tobacco-related illnesses (medical costs in 1990: \$22 billion), violence (medical costs in 1991: over \$4 billion); drug and alcohol-related costs (medical costs in 1990: approximately \$180 billion), low-birthweight babies (medical costs in 1990: \$2.6 billion), or illness caused by poor nutrition (cost in 1990 for coronary bypass surgery: \$8.5 billion; cost for treatment and rehabilitation from strokes in 1990: \$13.2 billion).
11. And an insurance card won't get a child to the doctor when his father is gone and his mother is working three jobs to make ends meet. Or the child of an alcoholic or drug abuser. A one-size-all-solution will truly be a one-size-fits-no-one.
12. We need to resolve three things:
- how to keep ourselves and our community in better health. We need to teach responsibility and values. We must address violence and addiction. We must also achieve greater health ourselves: we can avoid \$7 billion in annual hip fracture costs through better diet to avoid brittle bones of osteoporosis. Exercise can help control incontinence. Eliminating tobacco use could save \$65 billion in societal costs.
 - how to improve the quality and cost-effectiveness of medicine. How can we change incentives to produce more cost-reducing technology and less cost-inducing technology? How can we more effectively use the products we now have, including drugs, procedures, and devices? When can we expect real improvements from results-oriented outcomes research?
 - how best to prepare for the changes the future will bring. Our medical care needs will change dramatically over the next very few years. Medical breakthroughs, like the human genome project, will raise ethical issues never faced before. Our serious illnesses will be much less a function of acute illness like heart failure and cancer, and much more a function of chronic illness like Alzheimer's and incontinence. How can we induce the necessary transition in our medical infrastructure (human and physical) to focus on chronic illness and long-term care? We must shift our focus from the hospital to appropriate settings.
13. Simply changing our health care finance system cannot address all of these things. We must arrive at the direction for dramatic change together. But today, the American people indicate no clear preference for any specific type of overhaul and in fact, we all hold very contradictory views on how to address the inadequacies and costliness of our health care system.

14. I believe we should start by using some common sense. We must reform all sectors of our health care system. Interest groups cannot stand in our way. We must move now to reduce all health care costs.

- A. Lawyers: enact a federal medical liability law.
- B. Doctors: change the practice of medicine through removing incentives to over-prescribe or treat through medical liability reform; improving knowledge through reforms in medical education, and use and dissemination of medical outcomes research; empower patients through publication of fees and through a national registry for health care proxies and living wills to enable the physician to act upon the patient's wishes.
- C. Insurance: reduce administrative costs by requiring uniform claim forms and electronic claim submissions. Develop a "smart card" people can use like credit cards.
- D. Hospitals: eliminate unnecessary hospital beds by modifying antitrust rules that unnecessarily discourage hospital mergers and joint ventures; encourage electronic patient record-keeping.
- E. Change the way we buy health care services through the use of coordinated care and selective contracting in the private and public sector; establish Centers of Excellence for complex high risk procedures a national process for technology assessment maintaining incentives for cost reducing innovation and discouraging cost increasing innovation; research to improve our knowledge of biomedical and behavioral issues important to an aging society, including the bias toward acute and institutional care found in our current health care financing structure.
- F. Reduce the immediate and long term need for health care services through promoting health and preventing illness. No comprehensive reform alone can reduce costs enough to prevent health care from consuming unacceptable levels of the GDP; we must reduce the need for health care services.

15. We should (options):

- enact legislation to reduce medical liability costs
- enact legislation to make health insurance more affordable to small business owners and employees

- enact legislation that would make it easier to change jobs without losing coverage and would limit allowable premium increases after a major medical expense
- provide universal access to care now for all children under 12 through school area child health care centers and for all children and young adults under 25 through school-district based voluntary health insurance
- reduce administrative costs by adopting uniform claim and data systems
- oppose legislation that would mandate "cookie-cutter" benefits, and would limit personal choice and control
- oppose legislation that would put the government in charge of setting fees and deciding what services should be offered
- oppose legislation that would increase taxes
- reduce health care costs through better prenatal and other preventative care programs, and greater use of managed care in public programs and private insurance
- enhance access through community health centers and incentives for physicians to serve in rural and inner city areas
- commit ourselves to reducing health care costs by staying healthy, exercising, eating a balanced diet, avoiding drug abuse and excessive use of alcohol, avoiding tobacco, and reducing domestic and community violence

16. Addressing each one of these problems will provide immediate relief to millions of Americans who cannot afford health care or who cannot get health care. We must move on these initiatives now. But these steps alone will not accomplish the magnitude of change necessary. In order to keep health care costs at an acceptable level of GDP, reform must be comprehensive.

17. Comprehensive reform can be done by having the government run the health care system, or it can be done by reforming the private market. The Democrats propose various forms of national health insurance, global budgeting, employer mandates, and national commissions that will decide what services are available and when. As the Atlanta Journal said on March 20, 1992, "The Democrats clearly advocate enlarging government's role in

personal health-care decisions. For Americans angered by self-serving politicians, the idea of Congress and bureaucrats controlling a family's health-care benefits is bound to be a disturbing prospect."

18. The place for control in health care is not in the bureaucracy, it is with people. America should never face the time when people cannot control their own choices in health care. Today, there are three comprehensive reform ideas that challenge the notion that government control will reduce costs and achieve better health care for everyone; instead, these proposals are based on greater individual control.

1) The Heritage Foundation proposes that the tax advantages that create employer-sponsored insurance should be eliminated and replaced with tax credits that go directly to individuals to purchase insurance or to offset high medical costs. This proposal is based on the observation that significant reform cannot occur as long as individuals are isolated from the consequences of their actions by "free" employer-sponsored insurance. This plan relies on individual incentives and decision-making as its cost control mechanism. Mark Pauly and Patricia Danzon published through the American Enterprise Institute, and Regina Herzlinger published in the August, 1991 issue of *The Atlantic* variations on this idea.

2) President Bush's proposal would provide low and moderate income families with non-transferable tax credits to be applied to the purchase of insurance. It would give Americans long-term security by making health insurance available to all, guaranteed, renewable, and available with no preconditions. His proposal would reduce costs. The President would make insurance more affordable through the reforming medical liability, reducing administrative expenses, and encourage coordinated care.

3) Medical IRA/High Deductible proposals have been introduced by many Republicans in Congress. This proposals would allow tax-free savings accounts of up to \$4800 per year (\$600 additional for each dependent). Insurance policies would have a minimum \$2,000 deductible. This proposal relies on individual responsibility for smaller health care expenses, and returns health insurance to its original role, that of insuring non-budgetable levels of expenses.

19. These ideas prove how much of a crossroads we face this year. If the nation signs on to more government control, we will face in our entire health care system the same skyrocketing costs we have seen in the government's health care programs over the last twenty years. A plan based on market forces, sound economic principles, and individual choice and control is the only one that will work for America.

TALKING POINTS, #2

1. Major changes are necessary in our health care system.
2. Today, we face a simple choice in health care: should government control more of your health care, or should you? Should we give up more of our health care systems to Washington, or keep more of it between ourselves and our employers? Government-run national health insurance would have the compassion of the IRS, the efficiency of the Post Office, the expedience of the FDA and the cost of the Defense Department.
3. Various anecdotes to underscore the fact that we have to stay in America to find the solutions to America's health care problems:

Canada: has a population the size of California; has dramatically fewer drug and alcohol addicts as a percent of its population; has a dramatically less violent society; in recent years has experienced a rate of health care cost inflation almost exactly the same as ours (their GDP has grown faster than ours); does not allow for easy access to technologies and procedures; and all those who believed in a strong, central, and more socialized government moved north in 1776.

Germany: is a society that obeys government-imposed rules. The reason they have no speed limit on the Autobahn is because they know they would obey it. What would Americans do? Buy radar guns and routinely drive 9 miles faster than the speed limit. "Beating the system" is a part of the American ethic, and national health insurance for us would be one scandal after another of black market purchases, bribes and favoritism for cronies of politicians and administrators. We are an incentive driven society, not a bureaucracy-governed one.

4. I believe the private sector is the only way to maintain quality and innovation. Not one of us has had an illness among our family and friends without being thankful that we have a private sector health care system in this country. Now we must find ways to make it cost less and make it available to everyone.
5. To do that, there is no question that we must revolutionize the private market, to instill incentives for cost-reducing innovation and to eradicate fraud, greed, and waste. I need your help to battle the special interests who want to put your health care in the hands of the government.

6. I believe we must move immediately to enact comprehensive reform, including:

- make portable, secure insurance coverage available to everyone by prohibiting the use of exclusions and preexisting conditions and stabilizing rates by limiting the amount of any annual increase;
- extend insurance coverage to everyone by making it more affordable through tax credits, and reducing underlying health care costs through coordinated care and competition;
- enact a new medical liability reform law to eliminate "defensive" medicine and unnecessary testing;
- reduce the incentives for unnecessary medical procedures by prohibiting physician self-referrals; and
- crack down on fraudulent physician and hospital claims.

7. We must also begin to look ourselves in the mirror about our own health and what we expect of the health care system. No comprehensive reform alone can reduce costs enough to prevent health care from consuming unacceptable levels of the GDP; we must reduce the need for health care services. We should take strong action to:

- stop teens from using alcohol and tobacco. These are the "starter" drugs for even greater threats;
- focus a public health campaign on wellness and fitness; the potential for savings from proper nutrition and fitness is as great for older and young Americans alike, and the potential to improve the quality of life for seniors through delayed disability and decreased disability is virtually unlimited.

8. Now is the time to decide for yourselves or decide for bureaucrats. Be careful what you wish for, because if you wish for national health insurance now, you may be sorry when you get it. The consequences of health care reform will be serious. What will health care reform mean to you? I want to make sure bureaucrats don't call the shots, and that good health insurance and access to the best health care are available for everyone at a reasonable cost.

SUGGESTED STATE OR DISTRICT ACTIVITIES

1. Create a local community health care advisory committee of doctors, nurses, other healthcare professionals, hospital representatives, disease group representatives, insurers, Chamber/NFIB members and other employee groups, and local and state government officials.

Goal: Since there is no consensus, this rump group can ensure access on ideas, act as a hearing/sounding board, review proposals, give "outside-the-beltway" input. Local groups often differ substantially from their national parent organizations.

Activities:

- Analyze proposals
 - Analyze current local health care needs (like employer issues, rural issues, medicare reimbursement issues)
 - Answer questions
2. Health care speeches
 - A. Talk to and about what people care about -- their doctor, their insurance, their security.
 - B. Show you are not afraid of this issue:
 - visit with people in an emergency room, nursing home, or outpatient clinic;
 - attend a session of a couples' birthing class (healthy babies and mothers reduce costs);
 - visit with small business and/or farmers to discuss insurance reform and portability;
 - visit family aided by current health care quality in this country (young father of 5 who had a bypass or a disabled person contributing to the community);
 - visit a business that has successfully met challenge in reducing costs (local control, happy employees);
 - visit with doctors to discuss need for medical liability reform,
 - visit a successful Medicaid managed care program
 - meeting with disabled, someone who would have been fired without the ADA bill
 - visit an immunization outreach program; prevention is cheap

- C. Ask questions -- don't always have answers. Find out what the local health care issues are.
- 3. Do a health care newsletter
 - A. Define the terms
 - B. Educate constituencies
 - C. Insert Op-ed type pieces written by local constituencies
 - D. Ask for input, listen; personal views will be different than views on aggregate
- 4. Cosponsor legislation where there is consensus (medical liability reform; small market reform; health promotion, disease prevention). People want some problems solved now -- the ones they understand.

SAMPLE OR DRAFT NEWSLETTER INSERT

Vision for Comprehensive Health Care Reform

What Republicans Believe in:

1. **Comprehensive, market-based reform** that builds on the strengths of our current system to provide **access to affordable insurance for all Americans**.
2. **Provide access to portable insurance to all Americans.** Guarantee access to health insurance to all poor families through a tax credit large enough to purchase a basic health package. The fear of "job lock" -- where a worker can't move to another job without losing insurance should be eliminated. "Preexisting condition" exclusions are eliminated.
3. **Make insurance affordable by reducing health care costs.** Innovation in the private sector and increased personal control are the only ways to truly reduce health care costs. Through coordinated care and competition, health care costs will come down.
4. **Reduce administrative costs** by streamlining the current paperwork maze, and through market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.
5. **Restore common sense to the insurance industry.** By changing the rules for the insurance companies, millions of people who now can't find affordable insurance will be covered. People will no longer have to worry about big rate increases or being cut off after filing medical claims. And small employers will be able to join large pools to enjoy the buying power of bigger companies. Preempt state laws that stop innovative, cost reducing insurance policies.
6. **Enact medical liability reform** to stop the "defensive medicine" that burdens the U.S. health system.
7. **Expand services in underserved areas.** Rural America has a shortage of doctors and clinics. Incentives would encourage more of rural America's sons and daughters to return home as health professionals. Funds would be provided for emergency services.

8. **Ensure that children get care now.** Universal access to care now for all children under 12 through school area child health care centers and for all children and young adults under 25 through school-district based voluntary health insurance.

What Republicans Oppose:

1. **Regulating prices** will only result in reducing innovation, the creation of a black market for health care services and products, and will not reduce costs (witness the experience of wage and price controls in the 70's and the Medicare physician freeze in the mid-80's).
2. **Raise taxes on people or jobs.** Anything that reduces employment or raises taxes is bad for workers, their families, and small businesses in this economy.
3. **Reducing Medicare benefits or increasing Medicare premiums.**

POSSIBLE Q'S AND A'S

1. Last time I got a prescription, it cost me \$150. How can I afford this? What are my options? Why are drugs rising so rapidly?
 - over the next five years, 10 blockbuster drugs are coming off patent and there will be generic competition on many of these products. In addition, FDA needs to act quicker on the switch of products from prescription to OTC. Several are pending approval and the quickest way to see prices drop is in safely switching them to OTC.
 - pharmaceutical products should be covered by insurance
 - tremendous differences in prices between pharmacies: shop wisely
2. I am very fearful about generic substitution. My doctor tells me that he wants me to get a name brand drug, and the pharmacist offers me a generic at 1/3 the price. Are they safe? Or are they just rip-offs?
 - All generic drugs have been re-reviewed for safety and efficacy and all generic products currently marketed meet that test.
 - FDA has a very deliberate process to ensure that generic substitutes are "bio-equivalent" or act the same as the brand name drug.
3. Why can't we have a system like Canada? If you are sick, you go to the doctor. Today, if I'm sick it takes me weeks to get an appointment and then I have to wait and then the bill is enormous. What's wrong with Canada?
 - waits can be longer in Canada
 - technology less available in Canada
 - costs are increasing just as quickly in Canada
 - there is no one easy answer, not Canada, or Germany, or any other magic bullet
 - do you believe the federal government can do better than what we currently have?

4. My doctor says he won't accept my insurance and my insurance company tells me I have to go to one that they "pre-select." I like my doctor. He has been seeing me for years, he knows me, my conditions, and my family history. He is a good doctor. Why do I have to change?

- to lower costs, everyone will have to make changes: government, insurance, doctors, lawyers, people
- every doctor practices medicine a little bit differently, some are better than others, some are more expensive than others
- insurance companies are trying to find the best doctors, the best care at the best prices
- if you still want to go to a doctor you have previously selected, you might encourage him to become a part of your insurance company's network
- most insurance companies pay for visits to out-of-network doctors, but they may require you to pay more

5. I am covered by Medicare. Every time I read the paper, they are talking about cuts to the Medicare program. It scares me. I try to buy supplemental insurance policies. But, even so, they only offer me benefits not covered by Medicare. Is Congress going to cut Medicare?

- Medicare payment rates to hospitals and doctors have been reduced over the last decade. If we are going to reduce costs in health care, we must lower these rates
- program reforms have never gotten in the way of high quality medical care
- no beneficiary cuts have been enacted
- in spite of all our work, Medicare is the fastest growing program in the federal government and it threatens our ability to ever balance the budget we need to do more
- one proposal is to ask higher incomes beneficiaries to pay more for Part B premiums

6. My doctor complains to me about the hassles of the Medicare program. He says he spends more time filling out claims and fighting Medicare than seeing me. That's not fair and what are you going to do about it?
 - we all hate paperwork
 - last year we changed the way medicare pays doctors -- known as the RBRVS (resource based relative values system). This system will help us reduce costs in Medicare and tries to balance the value of different medical skills, like surgery and primary care.
 - the system has been in place only since January and no one likes change
7. My friend's son got in an accident recently. He's out of work and now has thousands of dollars of hospital bills. Why doesn't he qualify for federal aid, like Medicaid.
 - everyone needs to be insured. We have some laws on the books to help -- the 18 month extension of group coverage through COBRA for example -- but these are inadequate.
 - we need to reform our system to provide available, affordable coverage for everyone.
 - I believe (tax credits)(insurance reform)(President Bush's plan) will cover tragic circumstances just like these
 - Medicaid truly covers only certain "categorically" qualified people, primarily very low income women and children. Not every poor person is covered.
8. I keep hearing about real sick people who want to end their life, but instead are given all kinds of health care treatments. Why don't you stop this? Should we be saving everyone with everything we've got?
 - every individual should have the right to control his or her care, especially in terminal situations
 - two years ago, we enacted a living will or health care proxy to empower people to make these decisions.

- now, when you are admitted to the hospital, they must inform you about the need for living wills
 - when doctors and hospitals cannot rely on your instructions, they must protect themselves from lawsuits they must try to keep you alive
 - you are the only one who can help avoid this terrible and costly result
 - I do not believe government should ever try to decide who lives and who dies.
9. I understand AIDS is the chief reason health care costs are rising. Do you think our health care system should pay for a disease which is transmitted in such a bad way? I shouldn't have to pay.
- AIDs is only one small reason why this nation spends so much on health care - it will cost between \$5 and \$13 billion this year while we will spend close to \$800 billion for all health care in America
 - AIDs is a terrible disease that now inflicts many innocent people, many of whom received the virus through blood transfusions at hospitals or through sex with their spouse. This disease must be treated as a public health issue.
 - most AIDs patients are cared for through their private insurance policies as long as they are able to remain at work. If they have been disabled for more than 2 years, they are eligible for Medicare. If they are very poor and live in certain states, they may be eligible for Medicaid.
 - let's work to prevent the transmission of the disease and treat those who are afflicted with compassion.
10. My insurance premiums rose 20 percent last year. Why don't you just pass a law and cap the increases? Insurance companies are ripping us off.
- enacting insurance reform would do just that. But insurance costs are a reflection of the underlying costs of health care
 - technology, overuse, fraud, medical malpractice, antitrust, administrative costs, each component must be addressed

11. I read about a new treatment for Alzheimer's recently. However, they said that my mother couldn't get it for 10 years. Why? Do the government rules really take that long? My mother will be dead before it is available.
 - FDA requires all new treatments (drugs or devices) to be proven safe and effective before anyone in America can get them. Sometimes, complying with these rules takes 10 years.
 - President Bush has recently instituted short cuts to the process. While still preserving the integrity of the treatment to ensure it is safe, these shortcuts will reduce some of the regulatory controls for drugs aimed to treat life threatening diseases.
 - However, we in society are going to have to accept some risks if we want these treatments faster. It will require citizens to recognize that nothing is risk-free.
12. I understand that the federal government spends more for AIDS treatment and research than for cancer. I don't agree with that.
 - AIDS care and treatment dollars do exceed the federal spending for cancer research efforts but we spend more on cancer research than AIDS research. Also, AIDS is an infectious disease and a disease of the immune system. Many cancers have similar foundations. Finding treatment for AIDS may unlock the cures for other immune illnesses.
13. I live in a rural area and we are having a hard time just keeping a doctor in our community. The reason: Medicare's low payment rates. We can't afford to lose another doctor. What are you going to do?
 - Increase funding, amend recruitment techniques, and allow more flexibility in assignment for the National Health Service Corps
 - Provide grants to help rural areas with for ambulance and emergency care
 - Recruit potential doctors and health professionals from local areas and provide incentives to return to serve their own communities
 - Use technology to improve communication between isolated doctors and provide relief personnel to spell overworked health professionals

14. Every time I go to a doctor, he does this test and that test. And, every time my friends go, all they get are tests, tests, tests. Is all this necessary?

- We are fortunate to have such innovative diagnostic tools
- used properly they save lives and money -- mammograms, prostate exams, etc.
- all too often, they are used improperly: some fraudulent doctors want to make money, or doctors must satisfy a patient who insists on an MRI when an X-ray would suffice to protect himself against medical liability
- you can use your judgment. Ask you doctor why he is doing these things

15. My wife had surgery last year and she was in the hospital for five days. Her bill was \$15,000. The hospitals are ripping us off. The insurance companies wouldn't pay certain things. And, we got stuck. How did I know that two aspirins would cost \$9.00. I would have bought her a bottle for \$1.99. What are you going to do about this?

- Some of these outrageous bills are either gross negligence or fraud. We should investigate and prosecute if necessary. You can help by bringing these overcharges to the attention of your insurer.
- But some of these costs are the result of underpayment by Medicare, Medicaid, and workers compensation programs. This cost shifting is one of the reasons we need major reform.

16. There was a kid down the street who needed a liver transplant. His parents have good health insurance, but the treatment was not approved. His parents mortgaged their home, took all their savings, held fundraisers, and they still couldn't get the \$150,000. The hospital wouldn't even admit him until they had all the cash. Is this fair?

- experimental treatments are generally excluded from insurance coverage because of lack of proven effectiveness. Without these provisions, claims for treatments that constitute outright quackery or fraud would be difficult to deny.
- we must address this question as we approach health care reform. Who should get care? Who should get treatment? What kinds of treatments are cost effective? What kinds of treatment are merely futile?

- I do not know who is in the best position to make these types of decisions. We as a society will have to come to terms with these complex and difficult decisions and find ways of making appropriate judgments.
17. I had to go to an emergency room -- my kid broke his arm. We waited three hours before anyone saw us. The waiting room will filled. I am sure some people died before they got care. What are you going to do?
- today emergency rooms are overrun by improper use; people use emergency rooms as a place for primary care instead of making an appointment to see a doctor. And violence, closure of other trauma centers, and lack of payment for treating uninsureds has rendered most emergency rooms in critical condition.
 - doctors and nurses try to see most serious cases first
 - we need to get more community clinics open and more manpower to provide services. Please help me get citizens not to use emergency rooms unless it is just that -- an emergency.
 - we are also going to have to cure some of our social problems -- our violence, our crime rates. Crimes are taking an enormous toll on our health care system.
18. My friend works in a hospital. I tell her to stay away from those patients who have AIDS or hepatitis or tuberculosis. Don't you think they should be quarantined so their germs don't spread?
- hospitals are a dangerous place. There is no way to make them as safe as your home because of the very situations you are describing
 - but, disease transmission is only done through the exchange of blood fluids.
19. My mother is old. She isn't real sick, just getting old. However, she needs help. All the rules say the only way I can get help is to put her in a nursing home or the hospital. She doesn't need that. I can care for her some of the time, not all of the time. Why can't I get some help and keep her home?
- medicare has not kept up with the times. The fact is that people often need care for chronic illness that Medicare does not pay for

- recent legislation helps: hospice, respite care, home care, nursing home after hospitalization
 - real innovation is coming from the private sector. Insurance policies, home care, and managed care help move care from the hospital to more appropriate settings
20. My father had a MRI and it cost \$2000. Why is technology so expensive?
- costs of regulatory approval
 - liability costs
 - research and development costs
 - demand by consumers for new and better services
21. I wanted to change jobs recently but was fearful of losing my health insurance benefits. What should I do?
- we need to pass insurance reform so you don't have to worry
 - we must eliminate preexisting conditions and exclusions
 - we must ensure portability so no one ever faces "job-lock" again
22. Why do I have to pay for the health care costs of people who smoke? Why are you paying for tobacco farmers to grow tobacco?
- You shouldn't have to.

It's time for our nation's health care system to put hope and health within the reach of all Americans.

-- President George Bush

Americans today are worried about our nation's health care system. Families, individuals, employers, and health officials see the spiraling cost of doctor and hospital visits. And while many people fear losing their health insurance if they choose to change jobs, millions of others and their families have no insurance.

Clearly, it's time for change.

It's time for an American plan for health reform that builds on the strengths of our current system.

As Americans, we prize the freedom to choose our physicians, hospitals, and health care plans. We value the flexibility and diversity in how we receive our health care services. Quite simply, we want the best for our families and ourselves in life-saving medical technologies and in new methods to assure us quality health care.



Americans also want and expect value for our health care dollars. To that end, Americans want to eliminate waste in the health care system.

President Bush understands those American wants and needs. And he has proposed a sweeping plan to ensure Americans access to affordable, high-quality care.

The President's Comprehensive Health Reform Proposal will cut waste from the system and will provide health security for all Americans. The President's plans meet head-on the root causes of the problems in our health care system, not just the symptoms.

MEETING THE CHALLENGE OF COST AND ACCESS

We stand at a crossroads. We can move forward dramatically to reform our market-based system or we can force ourselves to swallow a cure worse than the disease.

-- President George Bush

The President's plan addresses the health care needs and concerns of three major groups in America:

- Consumers
- Business
- States



For consumers, the rising cost of health care during the past decade has meant less cash in hand for food, housing, clothing, and other essentials.

Rising costs of health care premiums and increasing deductibles have also led to less freedom of choice for many Americans. Many workers fear they will lose insurance if they change jobs.

Under the President's program, this so-called "job lock" is eliminated. The plan would also end limits on the availability of insurance for individuals with "pre-existing medical conditions."

The President understands that millions of Americans now have no access to health insurance. His program guarantees access to health insurance for all poor families through a system of credits with

which
buy ne

The Pr
targets
and mi
special
care.

The Pr
to meet

· Armin
inform
service
· Promo
health
· Reduc

For bus
health c
firms to
health c
workers.

In fact,
than 35
are depe
But man
small bu
cannot a
workers.

The Pres
reduce th
through r
that insur

- Giving States increased flexibility in the way they deliver health care services to the poor;
- Prohibiting laws that now limit enrollment in coordinated systems of care, such as health maintenance organizations (HMOs); and
- Eliminating costly State mandated health benefit laws.

These actions will enable States to more easily deliver high-quality, cost-conscious care to millions of poor people. And that, in turn, will help all States residents.

My plan will preserve what works and reform what doesn't. And above all, it will ensure every American universal access to affordable health insurance.

-- President George Bush

QUESTIONS AND ANSWERS

Q: If I already have health insurance, how will the President's program help me?

A: The plan will help you in three key ways:

- It will ensure that if you choose to change jobs, you will be able to buy affordable insurance and that insurers cannot keep you from getting

coverage because of a "pre-existing condition."

- It will significantly reduce the blizzard of paperwork that confuses consumers and unnecessarily drives up the administrative cost of care; and
- For more than 80 million low-income and middle class Americans, it will help allow tax deductions for part of the cost of health insurance.

Q: You talk about the importance of containing health care costs through insurance market reforms and reducing paperwork. Is that enough to make a difference?

A: No, and the President's program will do more. Other key reforms in the comprehensive package include:

- Medical malpractice reform to lessen the incentives for physicians to practice "defensive medicine";
- Greater use of electronic billing and patient records for reduced administrative costs; and
- Better information for consumers to make informed decisions about their health care.

Health

The President's Comprehensive Health Reform Program

Building on America's Strengths



*Our nation's fundamental
challenge is to give
Americans access, security,
and affordability in their
health care coverage.*

-- President George Bush

23. I want to eat right but I never know what is good for me. One day they say cut out cholesterol. The next day they say it's not that important. Every day I hear something different. What's the truth?

-- What we know about nutrition and health is improving every day. It comes down to the basics: select food from the four main food groups; and avoid excessive fats. And exercise hard for at least 20 minutes three times a week.
24. Why do you get free care just because you are in Congress?

DRAFT CONSTITUENT LETTERS

Below are some examples of draft letters you may wish to use or modify in responding to constituent concerns about health care issues, specifically health care reform, the Canadian system, and the Administration's proposal.

Draft letter 1: **HEALTH CARE REFORM IN GENERAL** (support for basic reforms; oppose Canadian system)

Thank you for your letter about rising health care costs and the need for solutions to get costs under control. Without question, there are many proposals before Congress on this issue and I am looking at each one with an eye directed at your concerns.

Our health care system is very diverse and complex. Simple, ready-made solutions probably will not work. Last year for many people health care costs rose at an astounding rate of 21.9%. Rising health care costs have been attributed to several things: increased utilization because of the aging population and advances in technology; and increased labor, marketing, and administrative costs. Nevertheless, we, as well as the private sector, are finding ways of controlling costs.

A first place to start is with our own thinking about health care. Every American must take more responsibility for their health care decision-making, including adopting health promotion and disease prevention actions on their own. The Office of Technology Assessment estimates that early and frequent prenatal care can save the U.S. health care system between \$14,000 and \$30,000 in newborn, first year and long-term health care costs. The lifetime custodial cost of caring for a low birth-weight baby can reach \$500,000. By adopting healthy lifestyles, therefore, individuals and society can benefit.

Another way to reduce health care costs is for Congress and state legislatures to adopt medical liability reform legislation. It has been estimated that 5-25% of all health care is unnecessary or inappropriate. Such health care spending has led to the practice of defensive medicine that results in billions of dollars of unnecessary health care costs each year. Important reforms are pending before Congress which calls on either the federal government or states to reform their tort laws and develop alternative dispute resolution systems to expeditiously resolve those cases where negligence is present.

Health care providers and insurers need to examine ways they can also reduce health care costs in our society. For example, they must work together to streamline claims payment and reduce unnecessary delays. Such delays are costing our health care system too much money and could be corrected with better use of computers and similar payment

mechanisms. Reducing administrative waste, cutting out unnecessary procedures and practices, and encouraging thoughtful uses of our health care dollar are goals we all must adopt.

While we all work to reduce health care costs, Congress must take a hard look at our federal health care programs -- including Medicare and Medicaid. Our senior citizens deserve to have a federal program which provides them with appropriate and quality health care services. In addition, Medicaid has become a nightmare as providers payments have been drastically reduced, beneficiaries have been declined services, and program cuts have been forced upon States. These programs can also benefit from greater consumer involvement, a reduction in overregulation, and a streamlining of information to the beneficiaries.

Our health care system must be changed, but we must not be tempted to adopt a Canadian-style nationalized program. Such a system eliminates individual choice, innovation in treatments, and an intolerable delay in receiving necessary care. A national health care system will result in decisions being made on the basis of the government's budget demands rather than on the need for quality health care for our citizens.

Help me to find solutions that continue to allow our citizens access to the finest therapies, most capable providers, and preserves individual choice and responsibility. We can do this without adopting more federal government regulation and bureaucratic abuse. Our society must ensure every American has access to our quality health care system without bankrupting our budget.

Thank you for your views. I hope you will let me know of your ideas and suggestions.

Draft letter 2: GENERAL HEALTH CARE REFORM (shorter letter in support of basic reforms)

I appreciate your contacting me about our current health care system. Your comments were insightful and I agree that Congressional action is necessary to fill some gaps.

Health care spending is over \$650 billion per year and consumes more than 12% of our Gross National Product (GNP). It is expected to grow to 15 percent if we do not make some changes in our health care delivery system.

There are many proposals pending before Congress which make good first steps at resolving some of our current inequities. For example, I support legislation to reform our health insurance marketplace for small business and individuals. Small employers may have a difficult time even obtaining health insurance for their employees because of the number of burdensome requirements that governments have imposed, making health insurance unaffordable. Proposals pending before Congress would repeal these various mandates so that small employers could purchase a health insurance benefit package that their employees want and that is affordable.

In addition, there are proposals before Congress to reform our medical liability system. It is estimated that between 5-25% of all health care spending is attributed to defensive medicine practices. Rather than supporting a legal system, let us redirect this spending to expand access to health services for all Americans.

There are other proposals, such as greater emphasis on health promotion and disease prevention activities, and prenatal care and well-baby care services, that are worthy of review.

However, I cannot support any effort which increases bureaucratic regulation which adds to health care spending. Administrative costs, caused by federal regulation, must be reduced so that we can spend more on services and less on red tape.

I look forward to your views on how our system can be changed. Health care reform is complex and difficult and I need your help in finding the best way to ensure we maintain a quality, health care system while expanding access to necessary care.

Draft letter 3: PRESIDENT BUSH'S HEALTH CARE REFORM PROPOSAL

Thank you for your letter about President Bush's health care reform proposal. Both parties agree that major reform is needed in our health care system. The President's leadership indicates clearly that he stands against government control of our health care system and your health care and that he stands for keeping choice in your hands and quality health care for your family.

Last year for many people health care costs rose at an astounding rate of 21.9 percent. These costs must be reduced. President Bush's proposal is the first step in the right direction. His plan will expand health care coverage, improve the quality of our health care services and control the skyrocketing costs.

Specifically, the President proposal will provide:

- assistance to make health insurance affordable to all middle income Americans;
- special help to all low-income Americans;
- help for more small businesses to afford to provide health insurance through insurance market reform;
- insurance portability so when people change jobs, their health insurance will never again be at risk; and
- lower health care costs through medical malpractice reform, reducing administrative costs, and encouraging coordinated care approaches.

If the President's plan is adopted, more than 95 million low to moderate income individuals would have greater access to health care. In addition, the President's plan will maintain the integrity and strengths of our current system that have made the American health care system the greatest in the world.

Most importantly, the President's plan does not provide for government intervention which means price regulation and rationing of health care services. It does not mandate that small employers provide specific, costly benefits that would mean the loss of jobs for many Americans. And, it does not require more taxes to pay for the expense of providing national health insurance.

The President's proposal adheres to important principles that will continue to allow our citizens access to the finest therapies and most capable providers while it preserves individual choice and responsibility. We can do this without adopting more federal government regulation and bureaucratic abuse. Our society must ensure everyone has access to our quality health care system without bankrupting our budget.

Thank you for your views. I hope you will let me know of your ideas and suggestions.

health

Document Originally
Attached to
Following Page

5/18

DEBORAH STEELMAN

May 15, 1992

Dear Richard:

This is the best piece I have ever read regarding the political dynamics of the health care debate and why reform always stays outside the grasp of the Inside-the-Beltway Crowd. Please do not put this in your read box. Please read it today. It is worth your time.

Debbie

A MUST READ!

FAULTY

PUBLIC MISCONCEPTIONS

DIAGNOSIS

ABOUT HEALTH CARE REFORM

PRINCIPAL RESEARCHER AND AUTHOR:

JOHN IMMERWAHR

CO-AUTHORS:

JEAN JOHNSON

ADAM KERNAN-SCHLOSS

A REPORT
FROM THE
PUBLIC AGENDA
FOUNDATION

P R E F A C E

In 1991, the debate on the condition of America's health care system escalated dramatically. Over 40 pieces of legislation to reform the health care insurance system were introduced in Congress. The surprising defeat of former Attorney General Richard Thornburgh by political unknown Harris Wofford in the Pennsylvania senatorial election propelled health care into the national political spotlight. Former Democratic presidential candidate Bob Kerrey made national health insurance the centerpiece of his campaign. Other candidates, including President Bush, have since offered their own proposals. The country's major news organizations have devoted admirable resources to covering the debate, and fully 70 percent of Americans now say they believe that the country's system of health care needs fundamental change.

It would seem that the awesome problem-solving power of democratic government will now be applied to health care. A problem has been identified. A debate has begun. Alternative approaches will be considered. The public will reach consensus. Leadership will respond.

But research conducted over the past two years by the Public Agenda Foundation in association with the Employee Benefit Research Institute (EBRI) and The Gallup Organization suggests that the national debate on health care is badly off course. Among political, business, and health care leadership, a debate of some focus and precision has indeed begun. But among the public, confusion, misunderstanding, fear, frustration, scapegoating, and wishful thinking characterize a discussion poised to go nowhere. While Americans care deeply about this issue and bring an important perspective and list of concerns to it, most approach health care from a radically different starting point than leaders do.

Our purpose here is to convey what we have learned about the public's starting point on health care. By doing so, we hope to help the nation's decisionmakers and communications media understand the enormous gaps that must be bridged if the country is to have a fair-minded, realistic, constructive debate on health care reform.

Public Agenda, with the support of the Robert Wood Johnson Foundation, is now launching a two-year citizen education project called **CONDITION CRITICAL**. Created in partnership with WGBH-TV (PBS) in Boston, **CONDITION CRITICAL** will be sponsored locally by television stations and newspapers across the country. Joining Public Agenda in this effort are the National Issues Forums, California Health Decisions, Georgia Health Decisions, and the New Jersey Citizens Committee for Bio-Medical Ethics, along with other educational organizations throughout the country.

Our collective hope is that this effort will help bring average Americans into the health care debate as full partners — armed with the understanding that will allow them to participate constructively. We also hope that leaders and news media will use this research in their own efforts to help Americans understand — and participate in making — the important choices this country faces on health care.

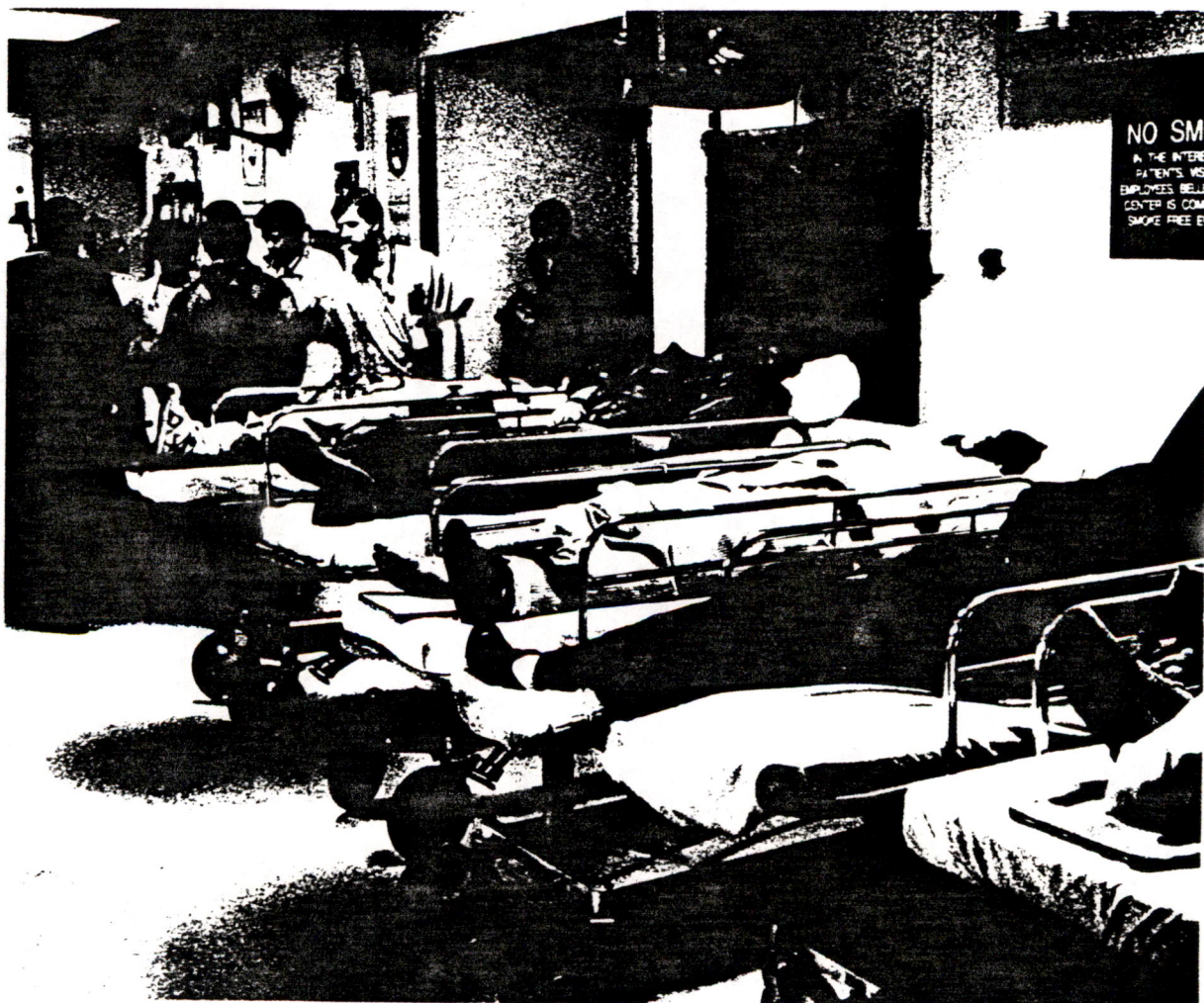
ABOUT THE RESEARCH

This study is the result of a two-year opinion research effort designed to illuminate the public's current level of understanding — the public's starting point — on this extraordinarily complex and difficult policy issue. The research began with a review of existing polling data on a wide variety of health care topics: the cost, availability, and quality of care; the cost, availability, and comprehensiveness of insurance; opinions on doctors, hospitals, insurance companies, employee benefits, the Medicare and Medicaid programs, medical technology, rationing or allocation of care, and health care in other countries.

Public Agenda then conducted 15 focus group discussions with citizens in cities across the country beginning in spring 1991 and continuing through winter 1992. Focus group sessions were held in Albuquerque, Atlanta, Baltimore, Boston, Chicago, Dayton, Dallas, Flint (MI), Los Angeles, Memphis, New York, Philadelphia (two groups), Portland (OR), and suburban

Washington, DC. These group sessions included in-depth questioning of cross-sections of Americans from around the country. These research sessions allowed us to probe beneath the survey findings and hear what Americans are thinking about the state of the country's health care system. Throughout these sessions, we heard similar concerns, questions, and viewpoints voiced repeatedly.

The research also included a two-part national opinion survey developed and fielded in association with the Employee Benefit Research Institute and The Gallup Organization. These surveys gave Public Agenda the opportunity to test hypotheses developed in the focus groups with random samples of the American public. Telephone surveys were fielded by Gallup in June 1991 and January 1992, each sampling the views of 1,000 Americans age 18 or older. Both surveys used standard random digit dialing techniques, and have a margin of error of plus or minus 3.1 percentage points.



GEORGE COHEN, IMPACT VISUALS

Research conducted for the past two years by the Public Agenda Foundation, in association with the Employee Benefit Research Institute (EBRI) and The Gallup Organization, suggests that the national debate on health care is badly off course. Although the American public and its leaders seem to have reached agreement on the major problems facing the health care system — soaring costs and inadequate coverage — just beneath the surface, the public/leadership consensus breaks down.

Many Americans are badly confused about the extent and causes of the health care cost problem.

"You are asking me to save money by watching some premature infant die when he has a chance of being saved, while you still are wasting the kind of money we are throwing away. No way."

They are frequently mistaken about which Americans have no health insurance. While paying lip-service to such proposals as "national health insurance," closer examination reveals that the public does not share leadership's definition of national health care. Current polling data showing consensus-level support for "national health care" may, as a result, be extremely misleading.

What is the cost problem?

For experts and leaders, the issue is that the country's total health care spending is out of control — estimated at almost \$750 billion in 1991 and rising at twice the rate of inflation.

For the public, the issue is that their own out-of-pocket costs are too high. Not only do Americans *overestimate* the contribution of their out-of-pocket costs to overall spending, they significantly *underestimate* what health care costs the nation as a whole. And they are unaware of how much they pay for health care indirectly — in taxes for Medicare and Medicaid; lower wages from employers burdened by high health insurance premiums; higher prices for products; etc. When respondents in focus groups were told that the nation as a whole spends twice as much on health care as on defense, they were incredulous.

Who are the uninsured?

For leaders and experts, the problem is the 35.7 million Americans whose companies don't provide coverage, who cannot afford to buy it on their own, and who make too much to qualify for Medicaid. They are

mainly the working poor and their dependents.

For the public, on the other hand, the problem is in a different area. A new survey shows that many Americans think large numbers of the elderly and very poor have no health care coverage at all, when, in fact, these are the two groups currently covered by government insurance programs.

Why are costs going up?

For leaders and experts, the health care cost problem is complex and multi-faceted. They frequently refer to factors such as duplication of technology and services, defensive medicine, the health costs associated with crime and drug use, an aging population, and the rapid development of new technology.

For the public, there is only one cause of high costs: greed. A survey for this study shows Americans blame high costs on unnecessary tests, overpaid doctors, wasteful hospitals, profiteering drug companies, and greedy malpractice lawyers. For the public, it all adds up to a *profits* problem, not a *costs* problem.

What should we do about the elderly?

For leaders and experts, the aging of the population presents a major challenge. The elderly have greater health care needs and thus account for a disproportionate share of health care spending: In 1991, citizens over 65, who make up only 12 percent of the population, accounted for over one-third of America's roughly \$750 billion health care bill. As the population ages, these costs are likely to rise, regardless of any policy changes.

For the public, the subject, when raised, touches a raw nerve. Most Americans do not believe that aging is a major factor in driving up costs. Even when presented with statistics detailing the higher health care costs for older Americans, most focus groups respondents were reluctant to consider the implications. As one Washington woman said: "It is true, but you shouldn't say it."

What should we do about technology?

For leaders and experts, both the inappropriate use of technology (duplication, unnecessary and unproven procedures) *and* the appropriate use of technology (the medical breakthroughs that improve and save



lives, but at a very high cost) are causes for concern.

For the public, the only problem is the misuse of technology — again, a matter of waste, fraud and abuse. The public resists suggestions that society may have to place some limits on what can be made available.

How much support is there for national health insurance?

Although experts and leaders disagree sharply about whether national health insurance is a good idea, they do share a common definition. National health insurance is a universal system paid for by taxes covering a majority of health care costs for every citizen.

Opinion surveys reveal broad public support (currently above 75 percent) for “national health insurance,” but this consensus is deceptive. Only 31 percent of

Americans define the term the same way that leaders do. In focus groups, respondents often believed that “national health care” would be optional, or that it would not be the responsibility of government. As one Flint (MI) man said, “I am for national health care, but I don’t want the government involved.”

How much support is there for “play-or-pay”?

Most respondents in focus groups had never heard of this idea, and many regarded it skeptically — believing, for instance, that it would drive small companies out of business. Some thought employers would prefer to pay a tax to the government rather than fund insurance policies for their employees.

The public’s top-of-the-head solution to any health care problem is to regulate costs and crack down on waste, fraud and greedy profiteering. However, the public does not believe that elimination of “waste” will mean less care for patients, only less profit for health care providers.

Lessons learned

The American public believes that the country’s health care system is riddled with waste and greed. Consequently, they are not eager to talk about hard choices, or to consider solutions that will increase their own costs or reduce the services they get. Nor are they ready to relinquish the miracles of modern medicine. As one New York man commented when asked about the high cost of attempting to save a severely premature infant: “You are asking me to save money by watching some premature infant die when he has a chance of being saved, while you still are wasting the kind of money we are throwing away. No way.”

The political debate on health care reform has leaped ahead of the public’s current level of understanding. Consequently, the national political debate is filled with miscues and crossed signals. The apparent consensus revealed in surveys is, instead, a house of cards that could fall apart with the first gust of reality.

Leaders should not expect quick solutions. Americans’ current attitudes took years to develop, and, in many ways, they are an accurate reflection of what leaders have explicitly or implicitly told them for decades. Change in their deeply-held values will come only gradually.

When treating an illness, doctors proceed through several stages, from detecting symptoms to diagnosing underlying causes and, finally, prescribing treatment. If the diagnosis is simple and the cure quick and painless, this can be done without the patient's support or cooperation. But if treatment is



U. ARMSTRONG HOBELITS

difficult — and especially if it involves behavioral changes or discomfort — then doctor and patient must agree on the nature of the problem and work together to effect a cure.

There is a similar process in public policy. Sometimes leaders can detect, diagnose, and respond to a problem without public understanding and outside the spotlight of public attention. But if the cure involves sacrifice, compromise, and changes in the way citizens live their daily lives, then the public and their leaders must operate from a common perspective. If citizens do not agree with leaders about the symptoms of the problem, or if they do not accept leadership's understanding of the causes, even the most elegant strategy will be ineffective.

How does the current policy debate about the country's health care crisis fit into this model? A superficial glance at the survey data suggests that the public is concerned about the country's health care system, and has agreed on a diagnosis and cure that is shared by at least some experts. Surveys show that the public, like its leadership, is alarmed by the skyrocketing cost of health care and the growing number

of people without health insurance. And the public, like some experts and leaders, favors a solution that has been around since the New Deal — a national health insurance system providing universal coverage and eliminating waste and duplication. Regardless of what one thinks about national health insurance, polls suggest that the public has thought about these issues and taken a stand.

But Public Agenda's research, which delved beneath the surface of these findings, suggests that this apparent consensus is a house of cards that will fall apart with the first gust of reality. Many of the terms of the debate — such as "national health insurance" or "health care costs" have such different meanings for experts and the public that the two groups are frequently not even talking about the same idea. The public's view of the health care issue is characterized by gaps, preoccupations, and misunderstandings that could derail any attempt to formulate a workable, long-lasting solution.

Some may be tempted to dismiss the public's views as evidence of apathy and ignorance, but the focus group research conducted for this study suggests a different picture. Virtually all of the respondents expressed deep concern about the country's health care system and genuine interest in finding ways to improve it. Many cited specific stories they had heard or read in the news, suggesting that these citizens were making some attempt to follow the leadership debate as reflected in the media.

Yet, despite respondents' ability to refer to particular news stories or to draw on their first-hand experience with the health care system, their understanding was often dangerously incomplete. Their conclusions were perhaps reasonable given what most people now know about health care. But many aspects of the health care system have been obscured from public view, and the current state of public thinking reflects this partial and incomplete understanding of a complex and difficult problem.

In the following pages, we describe some of the areas where the public's perspective on health care is most at odds with the perspective of experts and leaders. Until these differences are fully understood, and until leadership and media take steps to address them, the debate on health care will likely result in

continued political gridlock — with the public and leaders talking past each other and genuine long-lasting consensus elusive.

Political and health care leaders already are familiar with some of the consequences of poor communication with the public. In July, 1988, President Reagan signed legislation — the “catastrophic care bill” — putting a \$2,000 annual cap on what Medicare beneficiaries could pay in out-of-pocket costs and extending coverage to prescription drugs. The bill passed through Congress quickly with overwhelming bi-partisan support. Yet, just a year and a half later,

the President signed a bill repealing the act. Many of the elderly deeply resented the higher Medicare premiums stipulated to pay for the expanded coverage. Many also pointed out that the bill did not even address their major area of concern — long-term nursing home care. Leaders who thought this legislation would be broadly supported by the elderly were clearly taken by surprise.

To build a strong, stable consensus for any solution to the nation's health care dilemma requires — as the first step — clear and open communication between leadership and public. Today it does not exist.



WHAT'S WRONG?

Current polling data suggest that, whatever misunderstandings people may have about the details, they do seem to have a realistic grasp of the major symptoms of the health care crisis. When asked about problems facing the nation's health care system, people spontaneously identify two areas: the cost of health care and the number of people who are uninsured.¹ These are, of course, precisely the problems usually mentioned by experts and leaders as well.

On the surface, then, health care would seem to have a head start on other public policy problems where the country cannot even agree on the symptoms. In discussing competitiveness, for instance, the public frequently identifies Japanese ownership of American real estate, or low wages abroad as pressing symptoms of the problem — factors that most economists dismiss as relatively unimportant. On the other hand, the public is comparatively unconcerned

about the symptoms that trouble most economists, such as the nation's low productivity growth and low savings rates.²

A closer look at public attitudes on health care, however, shows that concern about cost and coverage do not really indicate a common understanding with leadership. In fact, the public and leadership perspectives are so different that they are more likely to be a source of conflict than a ground for consensus and compromise.

WHAT IS THE COST PROBLEM?

Superficial Consensus

The growing cost of health care is unquestionably high on the public's agenda of concerns. A survey conducted especially for this project by the Employee Benefit Research Institute (EBRI) through The Gallup Organization shows that nearly eight out of ten Americans (79 percent) think that health care



costs are growing at two or three times the rate of inflation. When respondents in focus groups were asked what first comes to mind when they think of health care, the comments were virtually unanimous: "Expensive." "Pretty soon we won't be able to afford it." "Exorbitant costs." More extended questioning, however, revealed how fragile the public/leadership consensus really is.

Underlying Disagreement

When leaders and experts discuss health care costs, they are typically concerned with the total cost to the country — federal, state, and local taxes devoted to health care, insurance premiums paid by business, along with what individuals pay out-of-pocket. In 1991, the nation spent close to \$750 billion on health care — twice what it spent on defense or education. Many experts now predict that the nation's health care bill will reach \$1.1 trillion by 1995.

To be sure, some leadership debate on health care costs is not really about controlling costs, but rather about "shifting" costs from one group to another — between the federal government and the states, for example, and/or between public and private payers. But most leaders, when they step back from focusing on the needs of their own institutions, are well aware of the costs to the country as a whole, and they are concerned about them.

The public, however, has a different understanding about "the cost of health care." On the one hand, many Americans often *overestimate* their personal share of health care spending — believing that their out-of-pocket costs for insurance premiums and doctor bills account for 70 to 80 percent of spending. One woman from Memphis said, for example, "In my household, we pay more for medical bills than any company or government, and I think that is the same for the nation as a whole." In fact, the truth is the opposite — with employers and government picking up 70 to 80 percent of the costs and individuals paying only 20 to 30 percent.

On the other hand, many respondents *underestimated* what the nation as a whole spends on health care. And, they *underestimated* what they actually paid for health care — in taxes to finance government Medicare and Medicaid programs, reduced wages or benefits

they receive from employers who instead buy health insurance, and higher costs for products.

Most respondents had very little conception of the size of the nation's health care bill. When presented with statistics showing that the country spends about twice as much on health care as on defense or education, many respondents were highly skeptical of the statistics. A few even questioned the motives or honesty of the focus group moderators.

In one Philadelphia focus group, respondents were shown a breakdown of the cost of a new automobile that suggested that \$700 of the total price went toward the cost of health insurance for auto workers. The respondents were incredulous. Several were convinced that there was a typographical error, and that the real figure was \$70 rather than \$700. A few seemed to have difficulty understanding that these costs are passed on to consumers. Referring to the \$700 figure for health insurance, one woman exclaimed, "But General Motors pays that." Some respondents were also skeptical of estimates of their share of taxes that goes toward health care coverage.

Policy Implications

These misunderstandings represent far more than a mere difference in nomenclature. The repercussions become evident when people begin to talk about solutions. A number of leaders and experts have proposed increasing consumer copayments and deductibles to bring greater market pressures to bear and encourage people to factor cost into their health care decisions. From the public's perspective, however, these kinds of changes are perceived as part of the problem rather than part of the solution. People seem to be saying: "My own costs are already too high. Why should I have to pay any more out-of-pocket?"

Indeed, perhaps without realizing it, the public has consistently called for the country to spend even more on health care, routinely endorsing higher government spending in this area. A 1990 survey by the *Los Angeles Times*, for example, found that 57 percent of Americans believe the federal government should spend more on health care, with only four percent

"In my household, we pay more for medical bills than any company or government, and I think that is the same for the nation as a whole."

"Health care is a business.
The people in the medical
field don't really care about
sick people. They are out
to make as much money
as they can."

wanting the federal government to spend less.³ An even larger percentage, 72 percent, believe that the government should spend more to reduce health care costs for the elderly.⁴ People often don't make the link that higher government spending might mean a higher tax bill for them.

From the expert perspective, these findings are absurd. It is inconsistent to complain about the increasing cost of health care, and then ask for higher spending levels. But from the public perspective, it makes sense. More government spending can reduce the rising cost of health care, if "cost" is understood to be only what people pay out-of-pocket. The public's assumption that out-of-pocket payments constitute the lion's share of health care spending is not wholly wrong-headed. The American insurance system — both government and private — has protected people against financial devastation, but it has also masked the true cost of health care. In some areas, there has been a systematic effort to disguise the real costs. Medicare, like Social Security, was deliberately designed to look like a self-financed insurance system. And, employer contributions to employee and retiree health care plans have been routinely buried out of the sight of most workers and consumers.

It is hardly surprising, then, that the public sees the health care problem as analogous to the automobile insurance problem. In both cases, the premiums are high and going up, and many individuals can't get insurance. What people don't realize is that, unlike auto insurance, what they pay directly is only the tip of the iceberg.

WHO ARE THE UNINSURED?

Superficial Consensus

When people are asked to list the biggest problems about health care, the second most commonly volunteered answer, both in open-ended surveys and in focus groups, is the number of Americans who don't have insurance.⁵ The predicament of America's 35.7 million uninsured also tops the expert and leadership list as one of the most pressing symptoms of the crisis in the nation's health care system.

Underlying Disagreement

Here again, however, the public's view of the problem differs from that of leadership. Most of the proposals being debated at the leadership level start from the premise that the elderly and the very poor already have at least some form of health insurance (provided by the Medicare and Medicaid programs). The pressing question for leaders is how to cover those Americans who are too young to qualify for Medicare, earn too much to qualify for Medicaid, and either work for non-insuring employers or are unemployed.

The public, by contrast, has not yet ticked the poor and the elderly off the list of the uninsured. The Public Agenda/EBRI survey indicates that people often are confused about precisely who does and does not have health insurance. Fifty-four percent of Americans believe that "many people over 65 have no health care coverage at all," and 64 percent believe that "many people on welfare have no health care coverage at all."

When respondents in focus groups were asked to describe a person without health insurance, they frequently envisioned an older person or a person on welfare. While some respondents saw lack of coverage as primarily a problem for part-time workers and those who work for small companies, other comments reflected the notion that it is mainly the old and impoverished who lack insurance: A Flint (MI) man said, "I picture an older person . . . trying to live off a Social Security check." A Memphis respondent said, "Who doesn't have health care coverage? Two different kinds of people — older people (a lot of them never had a chance to get insurance), and people who just don't care."

The image of the older person with no health care coverage is reinforced by the public's repeated exposure to TV commercials for Medigap insurance plans, and by the awareness that most older people do not, in fact, have health insurance to cover nursing home or long-term care.

Policy Implications

The public's different understanding of who will benefit from wider health insurance coverage has significant policy implications. Much public concern about coverage is driven by sympathy for older people and

the "truly needy." This level of public concern may change if people discover that the elderly and the very poor are already covered to a large extent. Conversely, enthusiasm for proposals to provide universal health insurance may erode when people learn that long-term care may not be included, or when they learn that the beneficiaries are likely to be younger working people — not the elderly.

Further, a 1988 Public Agenda study conducted for the Ford Foundation suggests that support for expanding health insurance drops sharply if new revenues must be raised for this purpose. Although respondents in that study strongly supported providing coverage for catastrophic and long-term illness for every American, only one in ten said they would pay a tax increase in the amount needed to finance such a program."

WHAT'S THE DIAGNOSIS?

A Complex Problem or a Simple One

The gap between leadership and the public widens when we move to a diagnosis of why health care costs are rising so dramatically and why the country has so many people with inadequate insurance coverage. Experts and leaders interviewed for this study generally view health care costs as a complex and ever-changing problem. Some of the many factors driving

up costs are specific to the American system of private health care — such as the overhead associated with multiple insurers (private and public), defensive medicine practiced by doctors and hospitals, an overabundance of specialists, and so on. Other cost-drivers are endemic to American society, such as the high health care costs associated with crime, drugs, teenage pregnancy, and fetal substance exposure.

At the same time, many experts also point out that, while the United States spends more per capita on health care than any other industrialized democracy, most advanced nations are experiencing a rapid growth in health care costs. Indeed, growth is faster in Australia, Canada, France, and Japan than it is in the United States.⁷ Experts point out that all of these countries — the United States included — face cost increases from the development of new medical technologies and the expenses associated with treating an aging population.

Waste and Greed

The public's diagnosis is much less complex. Costs are skyrocketing because of an age-old human problem that can be summarized in one word: greed. In every one of more than a dozen focus groups conducted in all parts of the country, including citizens from every demographic and socio-economic group, there was spontaneous agreement on why costs are rising: The health care system is rampant with waste, corruption, and profiteering.

The following comments are typical. A Los Angeles woman complained: "A lot of tests are unnecessary. Doctors have a vested interest in giving all of those tests. They have been telling everyone to have mammograms, but maybe they don't need them. Maybe they even cause cancer — it is radiation. When I was having my children, you never heard of Cesareans. Today everyone has them." Another Los Angeles woman complained, as did many others, about doctors' incomes: "In my work, I have seen the way doctors live and what they buy, and it is disgusting."

A Portland (OR) respondent questioned the motives of health care providers: "Health care is a business. The people in the medical field don't really care about sick people. They are out to make as much money as they can. They put in all of this expensive



PETE SALOUTOS / THE STOCK MARKET



LINDA EDEH-IMPACT VISUALS

equipment and technology, and they are giving us the bill. It isn't fair." Another Portland respondent described a system riddled with outright dishonesty and corruption: "Health care is a dirty business. There is a lot of money under the table. There are a lot of \$100 bills. The insurance companies invest in other areas. There is a lot of fraud. Major drug companies are pushing their drugs with ads and lobbying."

A Philadelphia woman also targeted drug companies for her condemnation: "Medication is extremely expensive. The taxpayers pay for all of the experiments. But once the medications are on the market, the people who make the product make the money, and we are paying on both ends."

"A Profits Crisis"

There was unanimity on one proposition: We don't have a health care *cost* crisis; we have a health care *profits* crisis. But there was substantial disagreement on who, exactly, is making all of the money. Everyone, it seems, has a favorite villain. The Public Agenda/EBRI survey showed that low-income people

are more likely to think physician salaries are the most important factor. People over 55 years of age are more likely to focus on drug company profits, while members of minority groups are more likely to point to insurance company profits. For the population as a whole, "malpractice" was most often named as the most important factor in driving health care costs.

For some, views about greed and waste have been influenced by media. Focus group respondents frequently mentioned news stories about high malpractice insurance premiums, million-dollar lawsuits, and scandals about local doctors bilking Medicare or Medicaid.

People also relied on personal experience. Nearly everyone had a story about a hospital bill in which people saw with their own eyes astronomical charges for items such as band-aids that they know can be purchased for a few cents. Many also cited outrageous mistakes in hospital bills. A Portland (OR) woman told a typical story: "When my granddaughter was in the hospital — she was five months old — we looked at the bill, and there was an item for occupa-

tional therapy. Really, she is just a baby! What is her occupation? When you sign that paper, you give them authority to do whatever they want." A Chicago woman offered another example: "My husband broke his leg, and they put this little bag with ice on it. And every time they changed the ice, they charged him some outrageous amount again." An Atlanta woman was appalled by the sheer waste in one hospital's standard safety procedures: "When they treat a simple wound, they open up a package, use what they need, and then throw it all away, including the scissors. Scissors are expensive! There is just so much waste."

Many respondents also had first-hand knowledge about malpractice problems, describing what had happened when they or their family members were in accidents. An Albuquerque woman described her experience: "My father got hit in the back of his truck. He might have been going about four miles per hour, but for three months afterwards, he had lawyers calling, wanting him to sue. The bumper of his truck wasn't even scratched, but they all said, 'Insurance will pay for it.' We are still getting letters."

Policy Implications

Many experts agree that there is a great deal of waste in the American health care system. Reforming malpractice laws and reducing unnecessary testing and procedures are at the top of many leaders' agendas. The problem is not that the public is concerned about waste and greed, but rather that people are so angered and so morally outraged, they are reluctant to consider any other additional causes or solutions. Even when factors such as advances in technology and demographic changes are suggested, people often try to explain them away as one more version of greed and waste. It is as if people see only a piece of the picture, and they are so angered and preoccupied by it, that they cannot take their eyes off of it. Greed and waste become an obsession, blinding the public to the rest of the picture.

The public's preoccupation with waste and greed explains some of the puzzling and inconsistent aspects of current public opinion. A few years ago, Dr. Robert Blendon of the Harvard School of Public Health pointed out that, while people are concerned about health care costs, they "support only the cost-

containment proposals that leave their personal health-care arrangements intact, and oppose solutions involving any major reorganization of the nation's health-care system."⁸ For Blendon, this was one more piece of evidence that the public holds "schizophrenic views" on health care and is unwilling to confront tough choices and potential sacrifices involved in reform. Cindy Jajiich-Toth and Burns W. Roper also have characterized the public's views on health care as "a study in contradictions."⁹

But in fact, Americans' reluctance to make hard choices is understandable when their overriding belief in waste and greed in health care is taken into account. As long as people recite anecdotes about ice — which is free in the hospital cafeteria — costing \$5.00 from the nursing station, they will be unwilling to contemplate sacrifices in their own health care.

WHAT ABOUT THE ELDERLY?

While few experts would contest the public's contention that there is a significant amount of waste in American health care, many leaders also believe that demographic changes will continue to push health care costs upward even if waste could be dramatically reduced.

Currently, people over 65 make up 12 percent of the population, but account for more than one-third of the \$750 billion annual bill for health care spending. As the Baby Boom generation becomes the Senior Boom generation early next century, one can only imagine how much higher the bills could go. One leading health-care expert, after insisting on anonymity, told us: "There is really only one way to stop the rise of health care costs — get all of us who are over 65 to commit suicide."

Misunderstanding, Discomfort, and Reticence

Research conducted for this study suggests, however, that most Americans do not understand that aging is a factor in the health care cost crisis. Nor are they ready to grapple with the implications of that demographic reality. When asked to choose which of three possible reasons (greed and waste, new technology,

"Medication is extremely expensive. The taxpayers pay for all of the experiments. But once the medications are on the market, the people who make the product make the money, and we are paying on both ends."

or a growing number of older people) is the most important explanation of increasing health care costs, the overwhelming majority of Americans (57 percent) select greed, waste and high profits. Only 20 percent select aging as the most important reason.

Younger people are especially blind to the aging factor. Fifty-four percent of those aged 18 to 34 believe

**"My husband broke his leg,
and they put this little bag
with ice on it. And every time
they changed the ice, they
charged him some outrageous
amount again."**

that "older people are no more responsible for growing health care costs than any other part of the population. Many of the most expensive medical problems happen most frequently to younger people."

Even people 55 and older — those most likely to have first-hand knowledge about the health care needs of the elderly — are evenly divided on this question. Forty-eight percent say the elderly are no more responsible for health care costs than any other age group, compared to 49 percent who believe that "one of the biggest reasons why health care costs are growing is that older people, who need more health care than any other group, make up an increasingly large part of the population."

There are many reasons why Americans are reluctant to accept the implications of our changing demographics. Focus groups suggested that many people simply do not understand that the elderly have more health care needs than other segments of the population. Some respondents seem to be influenced by television programming and advertising that celebrate the health, vitality, sexuality, and buying power of older Americans. While the frail and ill elderly are hidden at home or in long-term care facilities, vigorous older people are everywhere — exercising, traveling, enjoying retirement, even taking jobs traditionally held by younger people. This change has made a big impression on many citizens. A man from Los Angeles offered a typical comment: "I don't think older people are a reason why there are higher health care costs. I think older people are taking better care of themselves now and exercising more." A New York woman expressed a similar view: "Older people are much less important in health care costs than other things — like all of the waste."

Not only do people underestimate the amount of health care older people need, most completely fail to

understand why the phenomenon of more older people living longer will drive up health care costs for the nation as a whole. Moreover, since many people believe that each patient actually pays most of the cost for his own health care treatment, they don't understand why an older person's illness would increase their own health care burden — or be of any concern to society. People's comments on the elderly frequently reflect an overall lack of understanding of the economics of health care. Many focus group respondents simply did not understand that most health care costs are spread out among the population as a whole by either private or government insurance programs — and that, one way or another, all Americans help underwrite the medical treatment of those who fall ill.

A Philadelphia woman expressed her confusion openly: "Why should a growing number of older people run up my health care bills?" A man in Flint (MI), struggling with the concept, even suggested that more elderly should help *reduce* the costs: "I don't understand it. You have more older people, so you should have to charge less. It is supply and demand. Ten years ago we had fewer older people, maybe. Now we have more, so since more are coming through, it should cost less, not more."

A Portland (OR) woman, joined by many others, saw this problem as just one more indication of rampant greed and waste in the system: "The doctors are taking advantage of older people. They have to go to the doctor more often, so doctors raise the prices."

But even those focus-group respondents who understood how an aging population could drive up health care costs were extremely reluctant to talk about it. For some, it seemed almost indecent to mention the fact that older people have higher medical expenses. There is enormous sympathy and respect for older people. People believe that older citizens have made their contributions and deserve a comfortable and secure life. In focus groups, many respondents — both young and old — feared that any discussion of the high medical costs of the elderly was a prelude to urging some cut-back in services or benefits for the elderly.

In some focus groups, respondents were presented with statistics detailing the higher health costs for

older Americans. Many immediately assumed that the sponsors of the research were seeking to cut health benefits for older people. When asked whether they believed the statistics, many respondents admitted that they were probably correct. But many also shared the sentiments of a Washington, DC woman, who said, "It is true, but you shouldn't say it."

One Exception

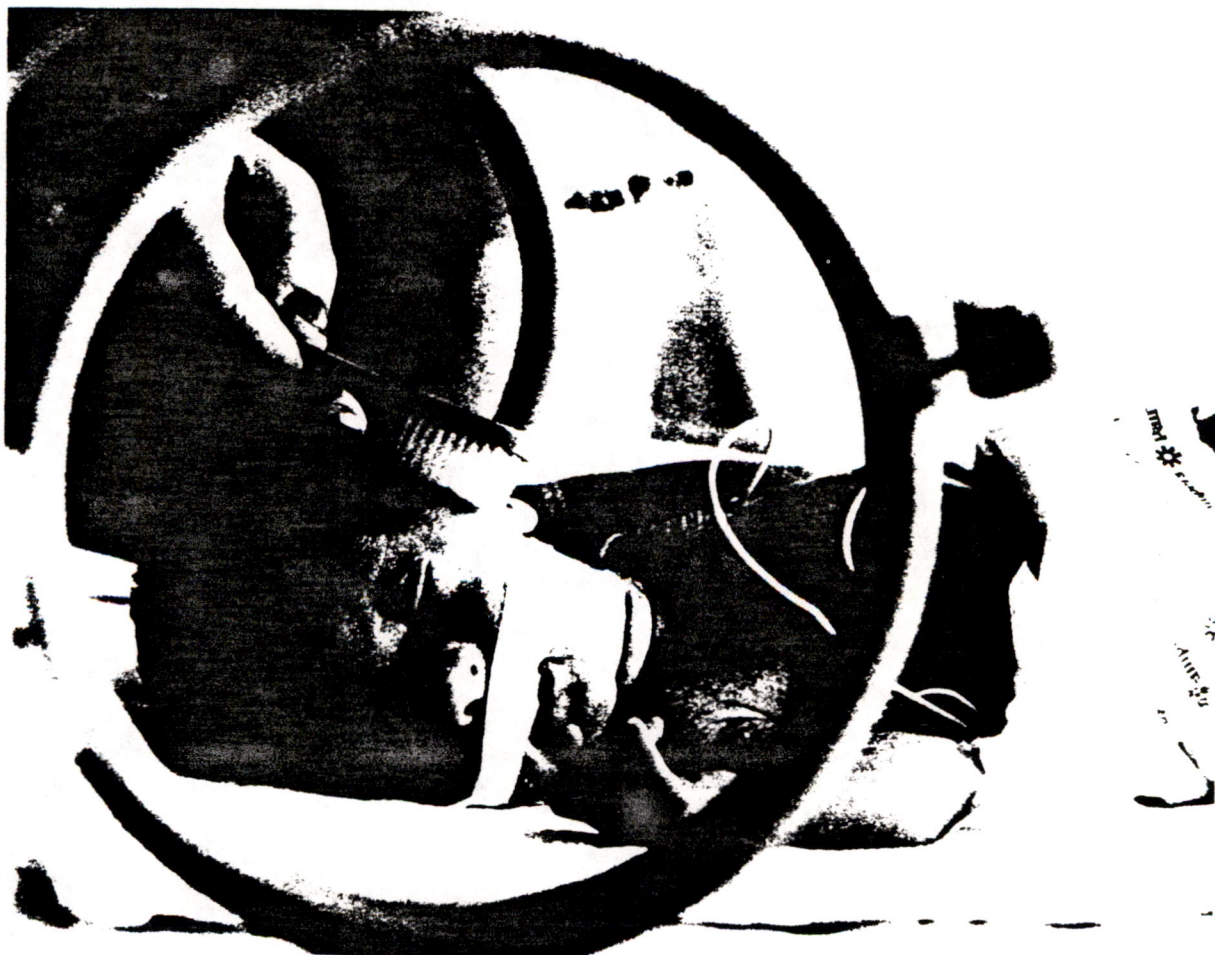
There was one area regarding health care for the elderly where many focus group respondents did seem to believe that "less" would be better — the intensive care provided in the very last weeks of a dying patient's life. Many respondents recounted stories about older relatives or friends whose lives had been prolonged against the wishes of the patient or family.

Most respondents — young and old — felt strongly that the family and the patient should be able to decide whether heroic measures should be used to extend life, although there were always one or two

individuals in each group who believed that life should be preserved in any circumstance. The majority of respondents seemed, however, more concerned that hospitals and doctors were seeking to "prolong death" at great human and financial cost. Some described incidents in which medical professionals seemed to operate on "automatic pilot" — ordering procedure after procedure, regardless of the family's wishes.

When asked why medical professionals would do this, people often thought that they either wanted to make more money on the dying, or wanted to cover all of the bases to avoid the possibility of subsequent lawsuits. A Dallas man said, "Extending life is a big factor in health care costs, and it is related to malpractice. They do that so they won't get sued. Doctors are often reluctant to cut off life-support systems even if the family says, 'That is what my grandfather wanted,' because they are afraid of a malpractice suit later."

Another woman described an incident in her own family: "My sister's son was in a motorcycle accident,



and they had him in intensive care for three days while they were deciding what to do. But the doctor told me he was really dead when he arrived at the hospital. I wonder how much all of that cost."

Research conducted by DYG, Inc. has also picked up changing public attitudes about heroic measures to save life. DYG's annual SCAN survey, which identifies and tracks social change, shows over the past four years a declining belief that human life is so sacred that "anything and everything should be done to keep individuals alive for as long as possible." The view that other circumstances must be taken into account has increased from a minority of 48 percent (in 1988) to a 60 percent majority in 1991. There is an even larger shift among Americans 60 years of age and older (from 40 percent to 64 percent) in the same period.¹⁰

Policy Implications

Given the widespread lack of understanding that an aging population increases health care costs, combined with people's genuine concern about the elderly, this particular topic is likely to have a "raw nerve" quality for many years. Research conducted for this study suggests that sensitivity about this topic affects all segments of the population, not just the elderly. This sensitivity often leads to overreaction to even the most modest recommendation to stem rising costs in this area.

The sole exception to this general reluctance was the willingness of many of the elderly themselves to talk openly about the misuse of technology in the last stages of life. Although the elderly often were extremely nervous, and in some cases even indignant, during discussions about reducing or modifying their coverage, they were frequently far more willing to discuss what type of care — and how much care — would give them the best chance to complete their lives in comfort and dignity.

WHAT'S THE ROLE OF TECHNOLOGY?

Superficial Consensus

Although most people did not want to discuss the cost implications of an aging society, they often were eager to talk about the cost of new medical technologies. The Public Agenda/EBRI study indicates that people seem to agree with experts and leaders that

new technology is a major factor in driving up health care costs. Nearly six out of ten Americans (59 percent) believe that "new medical technologies are driving up health care costs by extending people's lives and causing larger hospital and medical bills." Only a minority (39 percent) say that "the new medical technologies are helping to save costs in health care, as they have in every other industry."

Underlying Disagreement

But here again, the public's view is actually quite different from that of experts and leaders. Health care leaders, like the public, are concerned about the *inappropriate* use of technology — defensive medicine, unnecessary and unproven procedures, and so on. But leaders also are concerned about the cost of the

H. ARMSTRONG ROBERTS



appropriate use of technology — the medical breakthroughs that unquestionably improve and save lives. No humane society wants to deny such discoveries to anyone who can benefit, but progress can mean new costs, sometimes enormous new costs.

Advances in fields such as oncology and cardiology have added high-quality and productive years to the lives of many patients, but these medical miracles — provided to the thousands, sometimes millions, of Americans who can benefit — create both immediate and long-term costs to the country's health care system.

A person who would have died quickly (and with relatively low medical expenses) a few years ago can now be saved (often at great expense) only to live longer and expose the system to additional bills during subsequent illnesses. As Dr. Maurice McGregor

points out in a recent *New England Journal of Medicine* study of technology, "The cost of the health system increases in proportion to the success of each technological innovation."¹¹

The public, however, is oblivious to this issue and focuses almost entirely on the misuse of technology. Medical technology itself is widely admired. An Albuquerque woman, for example, said, "I think the new technologies are wonderful. They save a lot of money and a lot of time. I am just sorry they cost so much." An Atlanta man expressed another common view: "If I get sick, I want to get to the latest machine, right away."

Focus group respondents were quick to point to instances where technology, in their view, was misused. A Los Angeles woman said, "The best part is the brain power and the research and the universities. But that goes back to the worst part, which is that it doesn't go through the pipeline smoothly for the betterment of mankind, but gets chopped up by the money-making machine." Many respondents, such as this Atlanta woman, reported first-hand experience with what they saw as the abuse of technology: "My brother hurt his knee when he was playing ball, and they wanted to put him in that machine where they look at your whole body. I think they force that stuff on you."

"I don't understand it. You

have more older people, so

you should have to charge

less. It is supply and demand."

Policy Implications

The public's views on technology have serious implications for health care policies, especially those dealing with cost containment. The public's concern about the misuse of technology is essentially an extension of their overall concern — waste and greed are the root of the problem. If waste and greed could be eradicated, the public sees no real limit to the upward trajectory of medical progress. And, in the public's mind, the elimination of waste and greed does *not* include elimination of technology or services that benefit patients — or even offer a chance of benefiting patients.

This perspective contrasts starkly with the view of most leaders. Many leaders and experts have begun to believe that society has to place some limits on what can be made available. The real difference can

"If I get sick, I want to get the latest machine, right away."

be summed up in one startling set of survey findings from Louis Harris and Associates. While less than a quarter of political leaders (23 percent) agree that "health insurance should pay for any treatment which will save lives, even if it costs one million dollars to save a life," more than seven out of ten (71 percent) of the public endorses this statement.¹² The public

seems to be saying, "As long as none of this million dollars is wasted, as long as none of it is used to pay for sky-high salaries or profits, then spend the money. It's a good cause." These views make it difficult — if not impossible — to build support for cost-containment proposals that will limit or even slow the development of new medical technology.

FINDING A CURE: THE PUBLIC'S PRESCRIPTION

Given their different diagnoses of the problem, it is not surprising that leaders and the public would have different prescriptions for curing the health care crisis. Despite polling data suggesting increased support for national health insurance, the public has not really begun to wrestle with the implications of any solution to the problems of the health care system. Though people sometimes respond favorably to some leadership proposals presented to them in surveys, they also have, in the back of their minds, a solution of their own — one that goes directly to the heart of their diagnosis of the problem.

Focus groups conducted for this project suggest that the public has its own idea about what should be done to cut health care costs and provide wider coverage — an idea that is not much discussed by leadership. Not surprisingly, the public's solution directly follows its diagnosis: If greed is the problem, the solution is to control it. The Public Agenda/EBRI survey found virtual unanimity (83 percent) on the proposition that "the most practical and realistic way to provide health care coverage for people who don't have it now is to pay for it by cutting some of the waste, malpractice, high profits and salaries, or unnecessary paperwork in our current system."

When people were asked in focus groups how they would solve virtually any problem in health care, they invariably started from the premise that the solution

is to regulate costs and purge the system of waste and fraud. Many focus group respondents were particularly drawn to the idea of regulation and price controls. A New York man, for example, said, "There should be some regulation of the cost. It shouldn't cost \$15 for Tylenol." A Dayton man had a similar idea: "You have to control the costs for the doctors. You have to put a cap on how much these doctors can get, and the same for the drug companies. You have to put caps on it."

These statements reflect a widespread belief that health care costs are out of control, and that hospitals and doctors have a monopoly on health care and can charge almost any price they want. Most respondents seemed unaware that there are any limitations whatever on the prices that hospitals and doctors can charge. Many older respondents — particularly the middle-class elderly — were familiar with limitations on what Medicare will pay, but they did not seem to connect these caps with an attempt to control health care costs.

A number of focus group respondents called for changing the management of the health care system to bring a greater degree of accountability. A Dallas man said, "There are no checks and balances, and every hospital charges just whatever they want. The federal government ought to take control." An Atlanta man echoed this sentiment: "I think we need someone to jump in and look at the efficiency of the system, and see if you can get those costs scaled down. We don't mind paying, but we want to pay something that is reasonable in terms of the services." A Dayton woman suggested another way to wrest control from the health care professionals: "Get people like us to run it. Let the public have a say in what can go up and what can't go up; that way we could regulate it and have some say in what costs what." A man in the same Dayton group voiced a similar conviction: "You need to take it out of the hands of people who have a vested interest, and put it into the hands of people who care about people."

Of course, many people also were aware of the downside of their own solution, spontaneously pointing out oft-cited problems with excessive government regulation. A Memphis man, for example, offered his view: "Regulation — we are going to have to dig down and go with regulation. But all of a sudden, we have

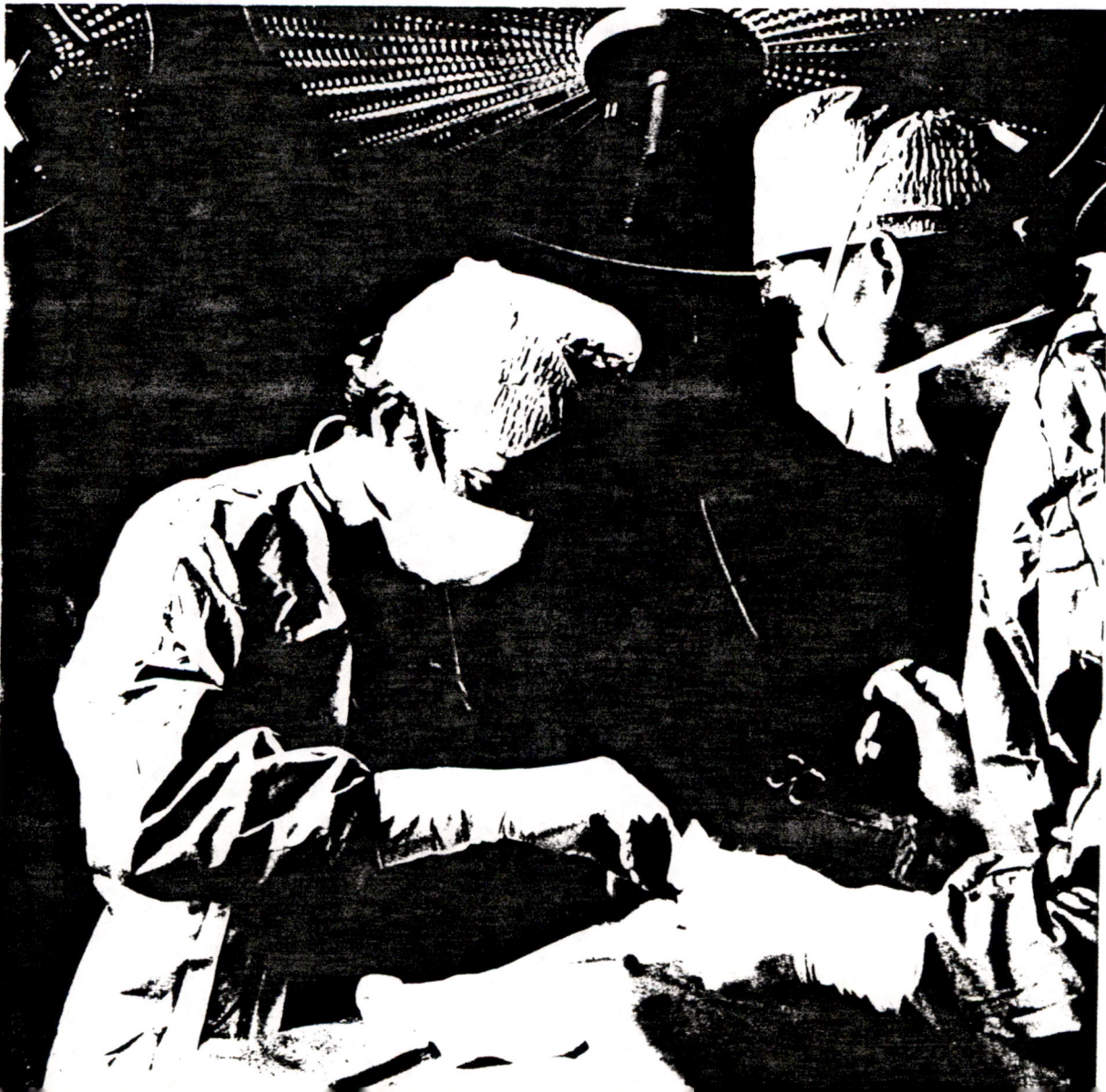
another government agency we are going to have to pay, so have you really gained anything?"

As people thought more about the difficulties of regulating the health care industry, they tended to locate the root cause of the problem in the broader failings of American culture: In other words, back to greed and lack of values. A Dayton woman said, "People will find ways around the regulation. You would have to get down to the moral training of the doctors themselves. That goes back to how you raise a child." A man in the same focus group echoed this theme: "The greed is everywhere, like in the auto industry — with the executives taking their millions across the top — to the stores, like Lazarus [Department Store] here in Dayton, that got taken over, and then they can't meet the debt. Our values are money."

This last analysis suggests, of course, that the health care problem is so deeply rooted that it is unsolvable, at least in the short run. This leads people to a glum pessimism — there is really nothing that can be done at all. From the public's perspective, there is either a simple solution (cut waste) or no solution at all.

NATIONAL HEALTH INSURANCE: THE DECEPTIVE CONSENSUS

What about national health insurance? Surveys have consistently found high levels of public support for this idea. Support for national health care rose above 60 percent in the early 1960s, just before the implementation of Medicare, then fell again. Support started to increase again in the mid-1980s, and has been



H. ARMSTRONG ROBERTS



steadily climbing since.¹³ The Public Agenda/EBRI survey conducted in February, 1992 documented one of the highest levels of support for this concept ever found, with 77 percent of the public favoring the "implementation, by the United States government, of some type of national health insurance."

Survey results at this level tend to suggest that a public consensus for national health insurance is already in place. But survey questions sometimes have a different meaning for the public than they do for the researchers who write them or the clients who pay for them. In the early 1980s, for example, scores of survey questions measured public support for the Strategic Defense Initiative (S.D.I) missile system, a highly controversial program that the Reagan Administration hoped to test and eventually implement. Most surveys showed strong public support for the system, to the consternation of liberals and the delight of conservatives. One study, however, asked not whether people supported the system, but whether the country already had such a system in place.¹⁴ Large majorities said that the system was already operative. While opinion researchers were asking about a system that did not exist (and accordingly many critics was technologically infeasible), much of the public was answering with reference to a system that it believed was already in place.

Research conducted for this study suggests that the debate on national health insurance may be similarly flawed. When experts and leaders talk about national health insurance, they usually mean a nationwide, universal system where government pays a large percentage of the health care costs for all citizens. There are different models of how this might actually operate, but this basic description is widely accepted among leadership.

Different Definitions

The Public Agenda/EBRI survey, however, suggests that this is not what most Americans have in mind when they hear the phrase "national health insurance." Only 31 percent of Americans believe that national health insurance will be a universal system covering the majority of health care costs for every citizen. Fifty-four percent think that national health insurance will cover only some medical bills, or even

none at all. Forty-one percent think that a national health insurance system will still leave some citizens without any health insurance at all. Even those who say they support national health insurance do not share the expert/leadership definition. Only 33 percent of those who favor national health insurance believe it will cover most or all health care expenses for every citizen.

In focus groups in Albuquerque, Flint, Dayton and Memphis, moderators asked respondents in one-on-one interviews what they thought a political candidate meant by the terms "national health care" or "national health insurance." Many respondents described something similar to the Canadian health care system ("health care for everyone, provided by the government out of tax money").

But significant numbers did not define "national health insurance" this way at all. Some people thought national health insurance was some type of optional insurance plan operated by the government in competition with private insurance. Others thought it meant another kind of government department. An Albuquerque man said, "It sounds like a government agency, where they spend a lot of money to find out what everyone thinks. The government will go in and get a group of people to find out if they can do something about health insurance." A Dayton man said, "I thought of GI insurance. I got into that years ago when I was in the Army, and I get good dividends on it. I think of national health insurance as a government policy that is optional, that people can buy into if they want."

For other respondents, the phrase evoked an image of universal insurance coverage, but not necessarily involving government. A Dayton woman described her reaction: "It means a more systematic health care system — I would like to see it — like Canada. It might be government, or it might be like an HMO. I was in an HMO for three years, and I liked it." An Albuquerque woman saw it as some type of private insurance venture: "National health insurance makes me think of an insurance agency, private insurance. There might be several different groups of agencies."

For still others, national health insurance meant

"There are no checks and balances, and every hospital charges just whatever they want. The federal government ought to take control."

government coverage, but only for those who do not have private health insurance. As one Flint woman put it: "I think of it as insurance for people who don't have it, funded by the government." A Memphis man said more wearily: "It usually means that I am going to have to pay for someone else's health insurance."

"When I was up in Manitoba, they had only one doctor for the whole area. And when he showed up in town, there was a line all the way around the block."

Fear of Government

Others emphasized ideas usually connected with national health insurance, but strenuously resisted government involvement. In Flint, one man said, "I think it means everyone should have the same health care, but I don't know who would fund it. I wouldn't want to turn it over to the government. They would screw it up." Another man added, "I am for national health care, but I don't want the government involved."

Despite its ambiguity, the phrase "national health insurance" clearly evokes a positive response. In the Public Agenda/EBRI survey, national health insurance is even favored by a large majority (68 percent) of those who do not think it will cover all citizens, and by an even larger majority (80 percent) who believe that it will cover only a portion of a citizen's health care costs. In fact, "national health insurance" — whatever the term may mean — is even favored by 56 percent of those who think it will mean lower quality in their own health care.

In other words, although support for national health insurance is at consensus level, people do not agree what a system like this would be like or what the effects might be. Fifty percent believe that national health insurance would decrease people's choice of doctor, while the other 50 believe that they would either have the same choice that they have now (41 percent) or even more (9 percent). Forty-eight percent think national health insurance means people would have to wait longer for tests, while 51 percent think people would wait the same or less time.

There was also no real agreement about what such a system would cost. Fifty-four percent say national health insurance would save money by eliminating paperwork and profits for doctors, drug companies, lawyers and insurance companies. At the same time, 52 percent think national health insurance would

increase the amount they themselves pay for health care in taxes, insurance premiums, and out-of-pocket health care costs.

When people are asked about specific plans for either national health insurance or universal public/private insurance, they express deep reservations. As other researchers have noted, when Canadian-style national health insurance systems are explained in detail, people start to back off from their initial support.¹⁵ Although many citizens are enthusiastic about the Canadian system, others spontaneously bring up objections — many expressing the belief that Canadian health care is inferior to that typically available in the United States. One Flint man, for example, had spent some time in Canada: "When I was up in Manitoba, they had only one doctor for the whole area. And when he showed up in town, there was a line all the way around the block." A Chicago man noted: "Heck, if anything really goes wrong with them, they come over here." And an Atlanta woman asked: "Wasn't there something on the news the other day about how they are having problems with that system too?"

In short, the high level of public approval in surveys does not mean that there is an authentic consensus for any specific proposal to implement national health insurance in the United States. Ultimately the sentiment, "I am in favor of national health insurance," can best be translated as "somebody needs to do something about health care."

PLAY-OR-PAY: NOT YET ON THE PUBLIC'S MENU

There was not much more enthusiasm for other proposals. In a number of focus groups, moderators asked respondents specifically about "play-or-pay" proposals — the idea all Americans would get health insurance either from an employer (who has decided to "play") or from the government (financed by taxes that non-complying employers would have to "pay").

Most respondents had never heard of this idea, and many regarded it with skepticism. A major concern was that it might force small employers to go out of business. A Philadelphia man predicted problems: "I see where a lot of small businesses would have to close their doors." A Flint man, based on personal

experience, raised the same concern: "You know what is going happen? The employer is going to lay off people. I have a small business. If they tell me I have to insure myself, I'd close the doors."

Respondents were generally skeptical that a mixed system of private and public health insurance could provide universal coverage. Many people thought that if government coverage were available to everyone who did not have private insurance, many employers would drop their private coverage plans and let their employees rely on public insurance. A Flint man predicted: "Then it would become like welfare, and employers would say, 'why should I provide coverage if people are going to get it anyway from the government?'"

For some leaders and experts, a key advantage of play-or-pay over national health insurance is that it is

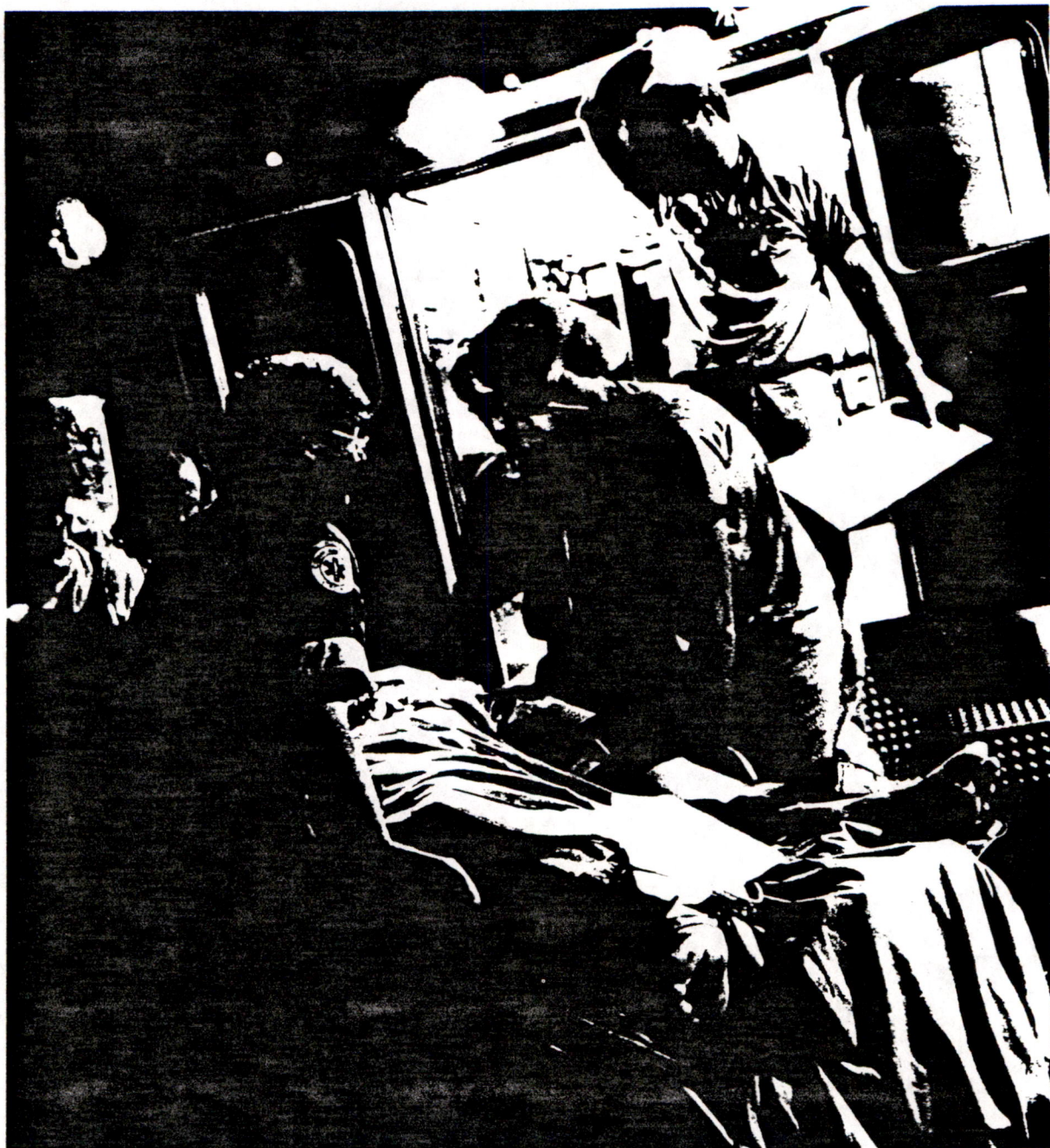
employer-based, not *government-based*. They see this as an advantage because they believe the current system has worked well for more than 80 percent of the population, and they are highly skeptical that government could do better.

For other experts and leaders, employer control is a disadvantage. They fear that such a system will inevitably be filled with inequities: some employers will be more willing to pay for (and more able to afford) better insurance coverage than others. These experts and leaders frequently believe strongly in *equal* access for all citizens.

Respondents in the focus groups were not aware of this debate. And, given their general lack of understanding of the health care system, many had difficulty distinguishing between the two approaches, even



H. ARMSTRONG ROBERTS



EUGENE HICHAIR, MAJ./JPHC PHOTOS INC

with the help of a moderator who continually reviewed and reiterated key points.

Drawbacks to Managed Care

Respondents also were unaware of another proposal receiving wide discussion among leaders — expanded use of managed care insurance plans. These plans either require or encourage patients to use doctors and hospitals that employers believe will provide the best care at the best prices. Frequently, this means that employees participate in HMOs or other “preferred provider” plans. There is often an attempt to regulate or at least review patient access to specialists or special care units.

The trend toward managed care is already well underway, and experts and leaders are actively debat-

ing whether these plans do, in fact, hold down costs. While respondents in the focus groups did not connect the use of managed care — a term which they did not understand and which moderators did not use — with an attempt to control costs, they did have opinions about its major features.

National surveys suggest that most Americans consider choice of doctor and hospital extremely important, and the comments of most respondents in this series of focus groups reiterated this point. A number of respondents were members of HMOs, or had been in the past. Some felt well-served by them, citing the easy access, good care, lack of paperwork, and minimal out-of-pocket costs. Other respondents had withdrawn from HMOs — primarily over the choice issue. A Baltimore woman said, “I used to be in an HMO, and

it was fine until my son had a special problem. The doctors there couldn't help me, so I had to get out."

Many respondents described the importance of being able to change doctors when they felt they were not getting the expertise they sought. In nearly every focus group, someone told a story about himself or an acquaintance who had to "shop" for the right doctor — not to look for a better price — but to find someone able to diagnose his illness correctly.

Despite the general discomfort with the idea of having less choice, a number of respondents — based on comments made in the focus groups — actually seemed to be in managed-care programs without realizing it. And among respondents who were in HMOs — or had been previously — virtually none realized that an HMO is a cost containment device.

Policy Implications

At present, the public is not, in any real sense, participating in the debate over how to cure the nation's health care ills. The high support for national health insurance in surveys does not mean that there is a consensus either for a Canadian-style insurance system or for other approaches to providing universal coverage. People do not understand the implications

of these changes or the implications of continuing with the status quo. In some sense, the political debate has leaped far ahead of the public. Moreover, there is some evidence that many Americans will resist giving serious thought to any specific proposal — until they have confronted the cost issue squarely and until leaders address their concerns about waste and greed.

WHERE DO WE GO FROM HERE?

Research conducted for this study reveals the significant differences between the way leaders and the public think about health care. Leaders and the public agree that cost and coverage are the main problems, but they see different pictures. Both groups are concerned about waste and greed in health care, but the public is so angered by the problem that it often refuses to confront other explanations for rising costs — aging and technology — and resists thinking seriously about specific solutions. For the public, waste in health care is almost an *idée fixe*. If leaders dismiss — or appear to dismiss — this concern, the public is not

likely to listen carefully. In addition, if leaders and experts leap forward to debate solutions — without real public understanding or participation — they are sure to encounter resistance.

Thus, leaders must deal with the waste issue head on. It will not be enough just to hear the public's concerns. Leadership will also have to take highly visible steps to address those concerns. There are literally hundreds of proposals designed to limit waste (including malpractice reform, establishing more rigorous controls on duplication of expensive technology, and so on). Until the public's concern gets a complete airing, it seems unlikely that the public will give much support to proposals that ask them either to pay more or make changes in their own health care expectations.

Some leaders may be tempted to see the public's preoccupation with waste and greed and their consequent disinterest in other problems as sheer obstinacy or selfishness — the desire to find an easy, painless, cost-free answer. But some comments from our focus groups suggest that the public's current thinking is not entirely selfish or unprincipled. As one New York man commented when asked about the high cost of saving the life of a severely premature infant: "You are asking me to save money by watching some premature infant die when he has a chance of being saved, while you still are wasting the kind of money we are throwing away. No way."

Finally, leaders should not expect quick solutions. Public attitudes toward health care have taken a long time to evolve to their present position. In many ways, the public's views are an accurate reflection of what leadership has explicitly or implicitly told them in the past decades. Leaders can easily become frustrated when the public does not immediately respond to the newest set of signals, but it is much more realistic to remember that change in deep-seated values will come only gradually.

Most of the health care reforms now being debated by leadership cannot possibly succeed without a substantial level of public understanding and support. Until the public's mindset and preoccupations are taken seriously — and responded to — these reforms will come slowly if at all.

"I am for national health care, but I don't want the government involved."

Giving citizens a basic understanding of what is at issue in the health care debate is a prerequisite to thoughtful, realistic debate. If people do not understand the staggering cost of health care to the country as a whole, if they continue to worry exclusively about their own out-of-pocket costs, and if they do not understand who is covered and who is not,

If Americans continue to believe that the high cost of health care is *solely* a reflection of greed and waste in the system, they will cling to easy, unworkable answers.

their views on how to reform the system will be impractical and possibly counter-productive. If Americans continue to believe that the high cost of health care is *solely* a reflection of greed and waste in the system, they will cling to easy, unworkable answers about how to reform it.

If they do not confront the cost of the indisputable benefits that modern medicine provides — longer life, better diagnoses, improved cures, and faster recovery times — wishful thinking will predominate. Citizens who believe this country's health care system can provide everything to everyone without any change whatsoever in their current personal health arrangements and expectations are certain to be disappointed.

Thus, to join the health care debate as full partners, Americans must understand the system more fully. They must think through the implications both of changing the system and leaving it as it is. During focus groups conducted for this study, Public Agenda had the opportunity to offer citizens a healthy dose of realism about the country's health care crisis. Many respondents struggled with new facts and information, and many initially denied the troubling dilemmas the health care crisis presents. But eventually most began to understand; they became engaged; they coped with disquieting questions about fairness and priorities, about what the nation can afford and what increased costs and inconveniences they themselves were willing to accept. Americans can participate in this debate — if efforts are made to explain the situation clearly and to lay out the choices fairly.

The jargon, technicalities, intricacies, and ethical quandaries of the health care issue are daunting, even to highly motivated and well-educated citizens. It is unlikely that many citizens will ever fully understand many of the terms and concepts commonly

used by experts and leaders in their own debates. But translation is possible. Moreover, including the public in the debate is essential if the country is to build a health care system that is affordable and meets the reasonable expectations and ethical principles of most Americans.

CONDITION CRITICAL

In an effort to bring the American public into the health care debate, Public Agenda has created prototype public discussion materials with funding from the Robert Wood Johnson Foundation and Baxter International. Developed initially for distribution in conjunction with "CONDITION CRITICAL: The American Health Care Forum," a national public television special produced by WGBH-TV in Boston and airing in spring 1992, these materials will be used throughout 1992 and 1993 by TV stations, newspapers, and community and educational organizations nationwide.



The American Health Care Forum

Designed specifically to address the misconceptions and gaps in knowledge identified in this study, the Public Agenda materials explain what health care in America really costs, who pays for it, who is insured and who is not, why costs are rising, and

other basic attributes of the American system. The materials also outline three leading proposals for reforming the system — both to broaden coverage and control costs. The chief arguments for and against each proposal are clearly described.

Initially, the Public Agenda campaigns, also called *CONDITION CRITICAL*, will originate in California, Georgia, and New Jersey. California Health Decisions, a non-partisan citizen education group, is hosting more than 1,000 community meetings throughout spring and summer 1992, leading up to a series of health care "parliaments" in the fall — all planned to educate citizens about the issues and solicit their informed responses to possible solutions. *The Sacramento Bee* with KQVR-TV (ABC) and KVIE (PBS); *The Orange County Register*, and *The Daily News* in Los Angeles will feature intensive coverage of the health care issue, including use of Public Agenda materials, to augment the effort.

Public Agenda also is working with Georgia Health

Decisions and that state's TV stations and newspapers to conduct an unprecedented citizen information campaign in spring 1992. *The Atlanta Constitution* and WSB-TV (ABC); *The Savannah Morning News and Evening Press* and WTOG (CBS); *The Augusta Chronicle Herald* and WRDW (CBS); *The Macon Telegraph* and WMAZ (CBS); *The Albany Herald* and WALB (NBC); and WTVM (NBC) in Columbus have formed an unusual coalition to bring the CONDITION CRITICAL campaign to Georgia's citizens. Following the media campaign, Georgia Health Decisions is hosting small group discussions throughout the state and sponsoring a survey of Georgians' values about health care.

Finally, New Jersey's Citizens Committee for Bio-Medical Ethics also is sponsoring a two-year CONDITION CRITICAL effort. Following this initial round of campaigns, Public Agenda will offer the project to communities nationwide.

In fall 1992, the National Issues Forums, a national consortium of educational and community organizations that regularly sponsor citizen discussions on important public issues, will join with Public Agenda to generate debate in more than 1,000 communities nationwide. The NIF effort will give tens of thousands of citizens the opportunity to debate health care choices, using a discussion guide prepared by Public Agenda specifically for use in these meetings.



DAVID M. GROSSMAN

"A Perception Gap." *Health Management Quarterly* (XIII: 3, Third Quarter, 1991, pp. 11-14). Daniel Yankelovich and John Immerwahr. This HMQ article is a preliminary report on the research described in this study. The volume focuses on the public debate on health care and includes articles by Humphrey Taylor (of Louis Harris and Associates) and Dr. Uwe Reinhardt on Americans' values regarding health care, and by Newton Minow and Fred Cate on the media's role in the health care debate.

CONDITION CRITICAL Information Kit. The Public Agenda Foundation. This kit describes — and includes sample materials from — Public Agenda's two-year citizen education project on health care that will be conducted throughout 1992 and 1993. Sample materials include newspaper print ads and a special supplement outlining three alternative proposals for reforming the American health care system. Materials in the kit describe how local media, community and educational organizations, and business can participate in these citizen education efforts.

Crosstalk: The Public, The Experts, and Competitiveness. A Research Report from the Business-Higher Education Forum and the Public Agenda Foundation. John Immerwahr, Jean Johnson, and Adam Kernan-Schloss. This report describes a gap — similar to that outlined in this study — between the way leaders and the public view the issue of U.S. economic competitiveness and the associated crisis in education and work force training. 1991. 24pp.

The Health Care Crisis: Containing Costs, Expanding Coverage. Prepared by the Public Agenda Foundation for the National Issues Forums. Keith Melville. A citizen's guide to three alternative proposals for reforming the American health care system. Written for the general reader, the guide discusses pro and con arguments for a national health care system, the "play-or-pay" approach, and a modification of our current health care system designed to expand coverage and contain costs. McGraw-Hill Inc. 1992. 48pp.

Health Care for the Elderly: Moral Dilemmas, Mortal Choices. Prepared by the Public Agenda Foundation for the National Issues Forums. Keith Melville. A citizen's guide to some of the difficult choices our society faces regarding health care for the elderly. Written for a lay audience, this guide outlines arguments for and against three different approaches to this issue. Kendall/Hunt Publishing Company, 1988. 48pp.

For information about obtaining copies of these publications and materials, please contact the Public Agenda Foundation, 6 East 39th Street, New York, NY 10016. Tel: 212-686-6610 Fax: 212-889-3461

1. MAP (Monitoring Attitudes of the Public), Health Insurance Association of America/Roper organization, 1990.
2. John Immerwahr, Jean Johnson and Adam Kernan-Schloss, *Crosstalk: The Public, The Experts and Competitiveness*, Business-Higher Education Forum and the Public Agenda Foundation, 1991.
3. *The Los Angeles Times*, January 21, 1990.
4. ABC/*Washington Post*, August 21, 1989.
5. Identified questions of the 70% of the population who call for changes in the health care system, cost problems were mentioned by 56 percent and access was mentioned by 32 percent. See Cindy Jajiich-Toth and Burns W. Roper, "Americans' Views on Health Care: A Study in Contradictions," *Health Affairs*, Winter 1990, p. 151.
6. John Doble and Keith Melville, *The Public's Perspective on Social Welfare Reform*, Public Agenda Foundation, 1988, pp. 43-44.
7. Employee Benefit Research Institute, *Issue Brief 106*, September, 1990, *International Benefits: Part One: Health Care*.
8. Robert J. Blendon and Drew E. Altman, "Public Attitudes about Health Care Costs: A Lesson on National Schizophrenia," *New England Journal of Medicine*, 311, August 30, 1984, p. 614.
9. Cindy Jajiich-Toth and Burns W. Roper, *Health Affairs*, Winter, 1990, pp. 149-157.
10. Daniel Yankelovich and John Immerwahr, "A Perception Gap," *Health Management Quarterly*, XIII: 3, Third Quarter, 1991, p. 14.
11. Maurice McGregor, "Technology and the Allocation of Resources," *New England Journal of Medicine*, 320, January 12, 1989, p. 119.
12. *Making Difficult Health Care Decisions*, Louis Harris and Associates for the Harvard Community Health Plan Foundation and the Loran Commission, 1987.
13. Robert J. Blendon and Karen Donelan, "The Public and the Emerging Debate over National Health Insurance," *New England Journal of Medicine*, 323, July 19, 1990, pp. 208-212.
14. Daniel Yankelovich and Sidney Harman, *Starting with the People*, 1988, p.83.
15. Cindy Jajiich-Toth and Burns W. Roper point out that "what at first appears to be active support for a government-run program turns to ambivalence as further aspects of such a system are presented." Cindy Jajiich-Toth and Burns W. Roper, *Health Affairs*, Winter, 1990, p. 135.

ABOUT THE AUTHORS

John Immerwahr is a Senior Research Fellow of the Public Agenda Foundation and a Professor of Philosophy at Villanova University.

Jean Johnson is a Vice President of the Public Agenda Foundation.

Adam Kernan-Schloss is a consultant to the Public Agenda Foundation and editor of its newsletter, *America's Agenda*. He has his own consulting firm, Kernan-Schloss Associates, in Alexandria, VA.

ACKNOWLEDGEMENTS

This study is the result of the efforts and encouragement of many individuals. The authors would like to express our thanks to:

Our colleagues at the Employee Benefit Research Institute for their invaluable assistance throughout this study. Laura Bos, Bill Custer, and Ken McDonell were especially helpful, and we would like to convey our special appreciation to Dallas Salisbury for sharing his experience, intelligence, and unflagging good humor with us throughout this project.

Carol Kelly, Jack Moynahan, and Barbara Willis of Metropolitan Life for their commitment to this project and their continuing interest in learning what Americans are really thinking about health care.

Geoffrey Fenton, Vernon Loucks, and Phil Smith of Baxter International for their role in this project. Without their concern and assistance, Public Agenda would not have been able to bring the results of this study to fruition with educational materials designed to bring more Americans into this important debate.

Our colleagues at WGBH-TV in Boston, Steve Atlas and Anne Speakman. We have learned from their creativity and expertise, and have appreciated their responsiveness and willingness to help on so many occasions.

Ellen Severoni and her associates at California Health Decisions. Ellen joined forces with us at the very inception of this project, sharing our commitment to informed public participation in the health care debate. She and her staff have been a true pleasure to work with.

Dr. William M. McClatchey and Beverly Tyler of Georgia Health Decisions and Mary Strong of the New Jersey Citizens Committee for Bio-Medical Ethics for their willingness to join with us in this important citizen education effort. We particularly appreciate the insights and ideas they have brought to the project.

Bruce Jennings of The Hastings Center for his thoughtful advice and guidance in planning and reviewing the research.

Our colleagues at the Charles F. Kettering Foundation and the National Issues Forums for their long-standing commitment to bringing citizens back into public policy decisionmaking. They have been our valued partners in many joint projects, and we especially appreciate the help of NIF's national network of discussion group moderators in this current health care project.

Finally, this project would not have been possible without the help of so many of our colleagues at Public Agenda: Bill Carr, Steve Farkas, Arlene Fliesler, Steven Immerwahr, Wendy Krantz, Keith Melville, Isaura Simon-Lavelle, Scott Swenson, and Jeffrey Tuchman. We are especially grateful for the support of Deborah Wadsworth, our executive director, who so tirelessly and enthusiastically worked to make this project a reality.

And lastly, we would like to express our gratitude to Daniel Yankelovich whose experience, breadth of vision, and wise counsel have been the underpinning of this work.

Funding for Public Agenda's research and citizen education project on health care

has been provided by:

Metropolitan Life Foundation

New Jersey Citizens Committee for

Robert Wood Johnson Foundation

The Metropolitan Life Foundation

New Jersey Citizens Committee for

Bio-Medical Ethics and the Fund for New Jersey

The WGBH Educational Foundation

COLLABORATING INSTITUTIONS

**THE EMPLOYEE BENEFIT
RESEARCH INSTITUTE**

2121 K Street, NW, Suite 600, Washington, DC 20037.
Tel: 202-659-0670

EBRI is a private, non-profit, non-partisan, public policy research organization in Washington, DC, established in 1978. EBRI's overall goal is to promote the development of soundly conceived employee benefit programs. EBRI works to achieve this goal through its research and education programs, which document, analyze, and disseminate facts on employee benefits. EBRI publishes policy studies, research reports, policy forum proceedings, and periodicals designed to contribute to the formation of effective and responsible health, welfare, and retirement policies.

CALIFORNIA HEALTH DECISIONS

505 South Main Street, Suite 400, Orange, CA 92668.
Tel: 714-647-4920

California Health Decisions is a non-profit community education organization based in Orange, California. Its mission is to involve the public in health care choices and to assure that community values are incorporated into health care policy. CHD is sponsoring more than 1,000 citizens meetings on health care reform in California in 1992. CHD is eager to assist groups throughout the country that want to launch similar efforts.

NATIONAL ISSUES FORUMS

100 Commons Road, Dayton, OH 45459-2777.
Tel: 800-433-7834

The NIF consists of thousands of civic and educational organizations — colleges and universities, libraries, service clubs, and membership groups — that each year sponsor non-partisan citizens' meetings on issues of public concern. These discussions are based on guides prepared by Public Agenda. NIF will address the health care issue in the 1992-93 academic year.

WGBH-TV

125 Western Avenue, Boston, MA 02134.
Tel: 617-492-2777

WGBH is one of the leading stations of the Public Broadcasting Service, recognized for excellence and innovation in television and radio programming. WGBH provides one-third of public television's prime time line-up and is considered the leader in public affairs and science programming. WGBH productions include *Frontline*, *Nova* and *The American Experience*.

Founded a decade ago by public opinion analyst Daniel Yankelovich and former Secretary of State Cyrus Vance, the Public Agenda Foundation works to help average citizens better understand critical policy issues and to help the nation's leaders better understand the public's point of view. Public Agenda's in-depth research on how average citizens think about public policy forms the basis for its extensive citizen education work. Its citizen education materials — used by the National Issues Forums and media outlets across the country — have won praise for their credibility and fairness from elected officials from both political parties and from experts and decision-makers across the political spectrum.

6 East 39th Street
New York, NY 10016
Tel: (212) 686-6610
Fax: (212) 889-3461

OFFICERS

Cyrus Vance
Chairman

Daniel Yankelovich
President

Maurice Lazarus
Executive Committee Chairman

EXECUTIVE COMMITTEE *

Ted Ashley
Warner Communications

John Diebold
The Diebold Group, Inc.,

Sidney Harman
Harman International Industries, Inc.

Frederick B. Henry
The Bohen Foundation

B.R. Inman
U.S. Navy (Retired)

David Mathews
The Kettering Foundation

Ann McLaughlin
The Urban Institute

Frank Stanton
Former President, CBS

Joe B. Wyatt
Vanderbilt University

EXECUTIVE DIRECTOR
Deborah Wadsworth

VICE PRESIDENTS

Jean Johnson
Keith Melville
Jeffrey Tuchman

POLICY REVIEW BOARD

The Hon. John Brademas
New York University

Robert A. Burnett
Meredith Corporation

Louis Cabot
Cabot Corporation

Patricia Carbine
Ms. Magazine

Edward W. Carter
Carter, Hawley, Hale, Stores, Inc.

Lisle C. Carter, Jr., Esq.
Washington, D. C.

William K. Coors
Adolph Coors. Co.

The Hon. Dick Clark
The Aspen Institute

John C. Culver
Arent, Fox, Kinter, Plotkin, and Kahn

Douglas Dillon
New York

John T. Dunlop
Harvard University

William D. Eberle
Ebco, Inc.

Marian W. Edelman
Children's Defense Fund

William Ellinghaus
Former President AT&T

Murray H. Finley
Amalgamated Clothing & Textile Workers Union

John W. Gardner
Stanford University

Walter E. Hoadley
Hoover Institute

Shirley Hufstедler
Hufstедler, Miller, Carlson & Beardsley

Vernon E. Jordan, Jr.
Aiken, Gump, Strauss, Hauer & Feld

Clark Kerr
University of California

Franklin A. Lindsay
Cambridge, Massachusetts

Sol M. Linowitz
Coudert Brothers

James McFarland
Minneapolis, Minnesota

Ruben F. Mettler
TRW, Inc.

J. Irwin Miller
Cummins Engine Company

Newton N. Minow, Esq.
Sidley and Austin

Eleanor H. Norton
Georgetown Univ. Law Center

Jane C. Pfeiffer
Greenwich, Connecticut

Elliot Richardson
Millbank, Tweed, Hadley & McCloy

George Romney
Bloomfield Hills, MI

William M. Roth
San Francisco, CA

Jerome S. Rubin
Times Mirror Co.

William Ruder
William Ruder, Inc.

Hershel B. Sarbin
Hershel B. Sarbin Assoc., Inc.

John Sawhill
Nature Conservancy

Donna Shalala
Chancellor, University of Wisconsin

Adele Simmons
President, The John D. & Catherine T. MacArthur
Foundation

Elmer B. Staats
Former Comptroller General

Lester Thurow
Massachusetts Institute of Technology

*Members of the Executive Committee also serve on the
Policy Review Board

File -
Healthcare

Document Originally
Attached to
Following Page

January 17, 1992

THE MITCHELL HEALTHAMERICA ACT: A BAIT AND SWITCH FOR AMERICAN WORKERS

INTRODUCTION

Among the most prominent in an array of health care reform measures now pending in Congress is S. 1227, the "HealthAmerica: Affordable Health Care for All Americans Act." The bill's prominence derives mainly from its sponsorship by George Mitchell, the Maine Democrat who is Senate Majority Leader.

The 349-page bill also is the most recent and comprehensive version of what is called the "play or pay" approach to health care reform. In this, the federal government would require employers either to "play" by covering their employees (and employee dependents) with at least a specified minimum level of health insurance or to "pay" a payroll tax to fund an expanded Medicaid-type program to cover their workers and dependents. The only employer exempt from this system would be the federal government. Buried in the bill is a provision that congressmen and their staffs, like other federal workers and retirees, would continue to enjoy a wide choice of private health plans.¹ The payroll tax would be set as a percentage of total wages paid to employees. The new government program created by S.1227 would be called "Americare." Co-sponsors of Mitchell's bill include Senators Edward Kennedy of Massachusetts and Jay Rockefeller of West Virginia, both Democrats.

High Costs, Adverse Incentives. While S. 1227 is a sincere attempt by Mitchell and others to address the problems of America's health care system, the sponsors apparently have not calculated the high costs and adverse incentives their bill would create for employers, consumers, health care providers, taxpayers, and government officials. According to an Urban Institute study released last week, the Mitchell plan would cost employers nearly \$30 billion per year more in

1 See Title II, Section 2713(3)(ii) of the bill.

insurance costs than they pay today, and would cost \$36 billion more in taxes than the legislation estimates for the public program to break even. Over 50 million Americans would be shifted from company-provided health plans into the expanded Medicaid-type public program, including over one-third of all currently insured workers.²

Among the specific shortcomings of the bill:

♦ ♦ A large number of employers could cut their cost of providing health benefits and avoid the red tape associated with company-based health plans simply by dropping their current private health insurance and paying the tax to enroll their workers in Americare. Consequently, many middle class Americans would lose their current generous coverage and be forced into an expanded Medicaid-type program, consigning them to a "one size fits all" level of coverage and quality of care. The Urban Institute estimates that 51.7 million Americans would lose their employer-provided insurance in this way. Over one-third of workers now covered by company plans would be forced into the public program. This is, moreover, almost surely an underestimate. Since employers that continued to offer insurance could be fined heavily by the federal government or sued by prospective employees if there were claims that the employer deliberately was not hiring individuals with family medical problems, many firms would opt to pay the tax to avoid the threat of litigation.

♦ ♦ The new employer tax payments and premium payments by families would fall far short of covering the actual expenses of the new program, leaving large deficits to be financed by taxpayers. The Urban Institute estimates that the plan's costs would outstrip income by \$36.4 billion annually. This means that payroll or other taxes would have to rise, destroying jobs, or that benefits in Americare would have to be cut.

♦ ♦ The employer mandate provisions would do nothing to control escalating health care costs. Mitchell apparently realizes this because his bill would create a massive, non-market, central planning bureaucracy to limit expenditures, control prices, and restrict capital investment for the entire U.S. health care system, including the privately insured sector. This is effectively the same structure used in the nationalized medical systems of Britain, Canada, and other countries that ration and deny medical treatments to cut costs. Mitchell's proposed central planning structure would create a shortage of medical services in the face of growing demand, and would limit or delay the adoption of new health technologies. Health care providers under such a system would have no incentive to improve or even maintain quality, or to innovate and develop new medical advances. Instead, providers of health care would have an incentive to do only the minimum required.

2 Sheila Zedlewski, Gregory Acs, Laura Wheaton and Colin Winterbottom, *Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs* (unpublished paper for the U.S. Department of Labor, Washington, D.C.: The Urban Institute, January 8, 1992).

The play or pay approach enshrined in the Mitchell bill would give the average currently insured worker and family a lower standard and quality of care, in a system of gradually deteriorating facilities and increasingly outmoded technology. Significantly, lawmakers have made sure that they would not be in the system they want to create. The Mitchell bill exempts Capitol Hill staffers and other federal workers and retirees from the health system that would apply to all other Americans.

Even those Americans who are uninsured today most likely would be worse off under the bill, though its primary purpose is to help them. Many would lose their jobs as employers cut payrolls in response to the high costs of expanded coverage mandated by the government. Many other workers would see their paychecks shrink as employers offset the new tax or insurance costs by cutting workers' cash wages. Past experience makes such responses by employers a near certainty.

No Compromise. The Mitchell bill is a poorly aimed reform effort. The proposal in no sense is a compromise, as its sponsors claim, between the current American system and government-run national health care. Rather, the system created by the Mitchell bill quickly would collapse into a full-scale, government-run system, with continuous budget problems and lower-quality care for most Americans. In short, the Mitchell bill is a classic example of bait and switch.

To be sure, America's health care system has serious flaws. But instead of trying to force employers to operate or pay for a national health care system, what is needed are reforms to establish a consumer-choice health care system in which the tax treatment of health spending is changed to permit families to choose their own health plan and in which government assistance to buy health care is targeted to the needy. Such a consumer-choice system would create powerful market incentives to control costs while increasing incentives on physicians and hospitals to deliver the highest quality medical care in the world.

HOW PLAY OR PAY IS SUPPOSED TO WORK

The Mitchell play or pay bill would require all employers either to purchase specified private health coverage for each of their employees and their families or to pay a new payroll tax to fund an expanded Medicaid program, renamed Americare, that would give such coverage. The federal government and its employees would be exempt from these requirements. Federal workers are covered by a system known as the Federal Employee Health Benefits Program, which allows them to choose between dozens of private health plans.

If employers chose to "play" by insuring their workers, the coverage they would be required to give includes specified services and sets limits on how much workers can be charged for the cost of their health insurance and medical care. In addition, new obligations and restrictions would be imposed on employers and insurance companies, including their hiring practices.

Among the Mitchell bill's key provisions:

1) Required Coverage.

Insurance plans provided by employers would have to contain unlimited coverage for inpatient and outpatient hospital care; inpatient and outpatient physician services, including dentist, optometrist, podiatrist, and chiropractor services; and diagnostic tests. Plans would have to cover prenatal and well-baby care, as well as preventive services—defined to include well-child care, pap smears, and mammograms. The plans would need to pay for at least 45 days per year of hospitalization treatment for mental disorders and for at least twenty visits per year for outpatient psychotherapy and counseling. States would not be permitted under the bill to raise the minimum level of coverage offered by employers above the level established by these federal mandates.

2) Cost-Sharing Limits.

Health insurance plans would not be allowed to impose annual deductibles on employees of more than \$250 or one percent of their wages, whichever is greater, for individual coverage or \$500 (or two percent of wages) for family coverage. This maximum deductible would be increased each year at the rate at which the Consumer Price Index rises. The payment for required services, which is the percentage of each charge that would be paid directly by the patient, in general could be no greater than 20 percent of that charge, except for mental health care where a co-payment of up to 50 percent would be allowed. The plans would have to include an annual limit on the total of deductible and co-payment fees payable by an employee. This would have to be no more than \$3,000 (indexed each year to consumer prices) or 10 percent of the employee's wages, whichever is greater.

3) Premiums.

Full-time employees, defined as those working 25 hours per week or more, could be required to pay up to 20 percent of the premiums for the mandated coverage under company-provided plans. Part-time employees, defined as those working less than 17.5 hours per week, could be required to pay up to 50 percent of the insurance premiums. Employees working between 17.5 and 25 hours per week, defined as less than full-time workers, could be required to pay between 20 percent and 50 percent of premiums on a sliding scale, depending on the average hours worked per week.

4) Insurer Regulations.

The mandated coverage could be provided through traditional insurance, a managed care program, such as a Health Maintenance Organization (HMO), or a Preferred Provider Organization (PPO). Individuals covered by an HMO or PPO normally pay a fixed monthly charge and are not billed for care from physicians or hospitals in the plan, although they can be charged all or part of the bill if they receive treatment from a provider not approved by the plan. Insurers would be prohibited from excluding or limiting coverage for any individual on the basis of

a pre-existing medical condition. This means that if an individual has been treated, say, for cancer in the past few months, or suffered from a chronic complaint such as diabetes, the insurer could not deny or limit coverage.

5) Anti-Discrimination.

Employers would be prohibited from discriminating in their hiring against workers because the workers are in poor health or have family members in poor health. For any failure to comply with this nondiscrimination requirement, the employer would be liable for all damages to the employee (that is, the cost of his or her treatment) and for a civil penalty of up to 15 percent of the employer's total wage payments for all employees for the year.

HOW THE AMERICARE PROGRAM WOULD WORK

The Mitchell bill would require those employers who choose not to provide the specified minimum private insurance described above to pay a new payroll tax. This tax revenue would go into the Americare program, which would give health insurance coverage to the employer's employees. The tax rate on employers who choose to "pay," not "play" is set in the bill as a percentage of wages. The percentage would be based on the cost of financing the Americare program. Sponsors estimate that the initial tax rate would have to be set at about 7 percent of wages.

Workers covered by Americare, in general, would pay 20 percent of the cost of their coverage. All workers with family income below the poverty threshold (about \$14,000 for a family of four), however, would be exempt from paying premiums. The premium paid by families above the poverty threshold would rise according to income up to 20 percent of coverage costs for workers with family incomes between 100 percent and 200 percent of the poverty threshold. In no case, however, would these workers have to pay more than 3 percent of family income in annual premiums. Part-time workers would pay no more than 10 percent of the cost of their coverage.

Americare Benefits. Americare would supply virtually the same benefits as would be required for the private insurance, with the same deductible and co-payment provisions.³ Workers and their dependents with family incomes below the poverty threshold would be exempt from the deductible and co-payment charges, with the full deductible and co-payment fees phased in gradually for those with family incomes between 110 percent and 200 percent of poverty.

3 The one difference is that Americare would provide children under 21 with "early and periodic screening, diagnosis and treatment," which includes regular physical check-ups and eye, dental, and hearing examinations, and any treatment that is found necessary as a result of such check-ups and examinations that may not otherwise be covered under the program. Families with private coverage could purchase such additional benefits from their private insurer, or could purchase such coverage from Americare by paying a premium to be set to cover the cost of those services.

Workers and their dependents with family incomes below the poverty threshold, or those who otherwise qualify for Medicaid, would receive through Americare any additional benefits included in the Medicaid plan of the state in which the family resides, except for care in a mental hospital, nursing facility, or hospice, or home health care. A state could add benefits to Americare for its residents, but would have to finance these benefits entirely out of state revenues.

Provider Reimbursement. The Medicare program for the elderly includes a schedule of fees for doctors and hospitals treating Medicare beneficiaries. These payment rates and reimbursement policies would apply to the services provided under Americare. This means Americare would pay physicians according to the controversial new relative value scale (RVS) system currently being introduced into Medicare.⁴ A state could choose to use its existing Medicaid payment rates and policies for the first six years after the legislation takes effect, but it would have to adopt the Medicare payment system by the seventh year.

Americare, therefore, would expand Medicaid dramatically, making it available to all working-age families, paying the full medical costs for all workers and dependents below the poverty line and charging a sliding-scale premium for other workers. Besides the taxes and premiums paid into Americare by employers and workers without private coverage, the program's remaining expenses would be financed jointly by the federal and state governments according to the existing Medicaid formula.

Financing. Since the bill would not require the program's taxes and premiums to be sufficient to finance Americare coverage, even for workers who are not poor, the program's budget will dip deeply into federal and state general revenues. Last week's Urban Institute study estimates that Americare will cost \$64 billion more each year than the revenue from its premiums and payroll tax, assuming a 7 percent tax. Current public programs for the non-institutionalized non-elderly cost \$28 billion, leaving a shortfall of \$36.4 billion to be raised from Americans through additional new taxes.

SPECIAL SMALL BUSINESS PROVISIONS

The sponsors of S. 1227 realize that their bill's mandates would impose a heavy burden on small businesses, which find it difficult to afford health insurance. They would be hard hit by a hike in payroll taxes. Included in the legislation therefore are special provisions for small businesses designed to ease those burdens.

⁴ See Robert E. Moffit, Ph.D., "Comparable Worth for Doctors: A Severe Case of Government Malpractice," Heritage Foundation *Background* No. 855, September 23, 1991.

First, the requirement to purchase the specified private insurance or pay new payroll taxes into Americare would not apply to firms with 25 to 100 workers until four years after passage of the act.

Second, such employers would continue to be exempt if the number of uninsured workers employed by them declined by 75 percent within the first four years. For firms with fewer than 25 workers, the initial exemption period would last five years.

Third, a complex and restricted tax credit would be allowed for the health insurance expenses of very small employers. This credit could be applied against the firm's taxes and would be equal to 25 percent of annual insurance expenses up to \$3,000 for each employee paid \$15,000 per year or less. The credit would be phased out for workers making between \$15,000 and \$20,000 per year and would not be available to offset the cost of insurance for workers earning above \$20,000. These phase-out levels would be indexed to increases in average wages over time. The credit would apply to firms with 40 or fewer workers, and phased out proportionally for firms with up to 60 workers. Even more confusing, the credit would be reduced proportionally to the extent that the employer's profits exceeded its annual health insurance costs, with the credit phased out completely when profits equaled three times such costs.⁵

The bill also would allow self-employed workers to deduct from their personal income tax the full cost of health insurance meeting the minimum requirements.⁶

Cost Control Regulations. In an attempt to constrain America's rapidly rising health costs, the bill would establish a Federal Health Expenditure Board. The eleven members of the Board would be appointed by the President, with the Senate's approval, and represent the public as well as health care providers and corporate purchasers of health care. This Board would set goals or target limits for the total amount of health care spending in the United States each year. The Board would set separate targets for spending on hospital services, physician services, laboratory services, pharmaceutical products, and other health services, as well as separate limits for health spending in each state. The Board also would set similar goals for the quality and availability of health care.

The Board would arbitrate between representatives of health care providers and purchasers. The aim would be for the Board to negotiate the terms and conditions of health care payments and delivery throughout America. It could seek, for example, to establish uniform payment rates for medical services, minimum standards for the quantity and availability of services, and a national plan for capital investments in new technologies and facilities.

⁵ Eligible employers could take this tax credit in addition to the regular deduction for employee wages and benefits (including health insurance) from corporate taxable income.

⁶ The bill also includes several provisions seeking to expand access to the private insurance market for small employers, such as requiring guaranteed issue and guaranteed renewability of policies to all small employers on the same terms as for others, regardless of the health status of the employer's workers. These provisions should be rejected on their own merits apart from the rest of the bill.

According to the Mitchell bill, the Board's negotiations would aim at assuring that its expenditure goals are met. Meetings of representatives from each major health care sector (such as hospital services and physician services) would be convened in each geographic area. These representatives, who would bargain on behalf of the consumer and provider interest groups, would be chosen by special petitions or elections or would be selected by the Board.

Based on Medicare. The payment system negotiated in detail in this way would be based on the Medicare payment system. If a majority of the negotiators for each side agreed on payment rates that the Board determined would achieve its predetermined expenditure targets or other goals, it would issue regulations enforcing the agreement. Those regulations would be legally binding on the providers and purchasers represented by the negotiators. If the negotiators failed to reach an agreement satisfactory to the Board, it could issue advisory regulations suggesting, but not mandating, maximum payment rates or other restrictions.

The Board also would establish a system of uniform billing by physicians and hospitals, as well as a uniform system of supplying information to purchasers. In addition, the Board would develop and introduce a system to measure the effectiveness of health care services.

Each state would be required to establish a consortium of all but the largest insurers in the state, to handle claims processing and payment for these insurers. The objective is to cut the supposedly high overhead costs associated with a large number of small competing insurers. Health care providers, large insurers, and corporate purchasers of health services also could join the consortium, and the federal Board could allow the consortium to conduct negotiations for the terms and conditions of health care within the state. To do so, these consortia would be given an explicit exemption from the antitrust laws.

A Quality Improvement Board would be established in each state to adopt guidelines for appropriate medical practices, recommend quality improvement, and develop measures of health care performance and outcomes. The Board then would certify certain health care providers in the state as outstanding providers based on their compliance with the Board's guidelines and recommendations. Insurers would be prohibited from denying payment for any services performed or ordered by a certified outstanding provider unless the service in question is not covered by the policy.

MEDICAID FOR THE MIDDLE CLASS

The proponents of the play or pay approach at one time argued that it had the virtue of simplicity. It would simply extend the current employer-based system while giving employers a straightforward choice—provide coverage or pay a tax so that the government could provide coverage. But as the 349-page Mitchell bill indicates, setting up such a system is far from simple. Worse, the legislation would not work as advertised.

Among the problems with Mitchell's pay or play:

Millions of Americans would be dumped into the public program.

S. 1227 purports to allow a choice between private insurance and the public Americare program. In reality, however, it would lead to millions of workers being dumped into the public Americare program, including those who now have employer-provided insurance. This is because the proposed legislation would give most employers the incentive to pay the new Americare payroll tax and drop the private insurance they now give their workers.

It is not hard to understand why dumping would be widespread. The current national average cost of employer-sponsored health insurance for workers with family coverage is about \$300 per month, or \$3,600 per year. The minimum health insurance package mandated by S. 1277 is more generous than typical company-provided plans, and so would cost at least as much as the current cost of an average plan. The 7 percent payroll tax rate for Americare would cost the employers less than the insurance premiums now do for employees earning less than \$51,000 per year.⁷ The average taxable wage in the U.S. work force is now about \$25,000 per year.⁸ Thus, the great majority of companies have average per employee payrolls of less than \$51,000 per year and would save money by dropping their current private coverage, dumping their workers into Americare, and paying the payroll tax instead.

If the Americare tax were set at a high enough level to cover true costs, and if Americare coverage were to be comparable to average plans in the private sector, the cost of Americare for employers with workers making the average wage would be roughly the same as the cost for private insurance. Since Americare is financed by the same percentage tax rate applied to all covered payrolls, however, the tax cost of Americare would decline proportionally for employers with workers earning below average wages, while the cost of mandated private insurance would be at about the same level. As a result, there would be a greater incentive for firms employing lower-paid workers to shift them into the public plan—while the payroll tax revenue to finance their coverage would tend to be well below the actual cost of services.

⁷ For an employer with an average per employee payroll of \$51,000 per year, the cost of Americare would be 7 percent of \$51,000, or \$3,570 per employee. This per employee cost would fall proportionally for average per employee payrolls below \$51,000 per year. The cost of the private insurance at an average employee contribution of \$300 per month would be \$3,600 per year for all employees. Consequently, the cost of Americare would be less for all employers with average per employee payrolls of less than \$51,000 per year. The small business tax credit would not change this as it is phased out at lower income levels where the Americare tax would still be less than the private insurance premiums even with the credit. At \$15,000 in wages, where the tax credit begins phasing out, the 7 percent Americare tax would cost \$1,050 per year. But \$300 per month for the private insurance with a 25 percent credit would still cost \$2,700 per year. While the legislation specifies that the tax rate should be set so that at least one-third of the uninsured would be covered by private insurance, this is unlikely to occur unless the tax rate is raised sharply from its currently proposed 7 percent. More likely, the one-third requirement for private coverage will be dropped.

⁸ S. 1227 would use the same definition of taxable wages as Social Security without any maximum taxable income cap.

Opting for Public System. If the Americare tax rate is set far below the true cost, however, then far more employers would opt for the public system. At 7 percent, the Americare tax rate would be far below the true cost of either private or public coverage. The average private premium of about \$3,600 per year per employee, which reflects true costs, amounts to about 14 percent for an employee earning the national average wage of \$25,000. This is consistent with estimates that corporate health care currently costs about 14 percent of payroll for covered employees.⁹

Thus, all employers with average per employee payrolls of less than twice the national average wage would save money by dumping their workers into Americare.

For the Americare tax to be equal to the average cost of health insurance for workers with average earnings, the tax rate would need to be increased from 7 percent to 14 percent. Even at this higher tax rate, employers still would save money by dumping workers with below average wages into Americare.

Last week's Urban Institute study estimates the effects of such incentives using a sophisticated simulation model incorporating data on employers' health insurance premiums as well as population and payroll data. The study assesses a play or pay plan like that in the Mitchell bill, assuming a 7 percent payroll tax for employers choosing the "pay" option.

Huge Additional Costs. According to the Urban Institute, Americare would end up covering 52 percent of all Americans under age 65, or some 111,900,000 individuals. The Urban Institute study projects that 51.7 million workers and their dependents now covered by an employer-sponsored plan would be shifted into the public plan. The study finds that 81.5 percent of all the employees of small firms (less than 25 workers) would end up in the public plan.

Calculating the tax and the required benefit package for company-provided plans, the study estimates that the cost to American companies each year of paying the tax or providing health benefits would be \$29.7 billion more

Annual Increased Cost in Health Insurance for Business Under Pay or Play		
	billions of dollars	% increase costs
Small Firms	\$11.0	+71%
Medium Firms	\$ 9.7	+21%
Large Firms	\$ 9.1	+13%
Total Extra Cost to Employers	\$29.7	+23%
Source: Urban Institute/Department of Labor		
Note: numbers may not add up due to rounding.		

9 "Its Cheaper to Pay Than It is to Play" (Washington, D.C.: The NFIB Foundation, 1991), p. 8, citing *Business Insurance*, June 21, 1991.

than they currently spend on health insurance, an average increase of 23 percent. For small firms, the cost would be an average rise of 71 percent.

Despite these increases in costs, the Urban Institute study confirms that a 7 percent tax, combined with the schedule of premiums for Americare, would not cover the cost of the program. The shortfall, which would need to be covered by taxes beyond the new payroll tax, would be an estimated \$36.4 billion each year.

Endless litigation would increase dumping.

Other factors too would prompt employers to abandon the private insurance coverage they now give their workers, even if the costs were roughly equivalent. These factors would increase the size of the public program beyond the Urban Institute's projections.

The most important of these factors is that by shifting their workers to Americare, employers would avoid the threat of being slapped with lawsuits alleging discrimination against existing employees who posed potentially high medical costs. If a worker or job applicant in poor health or with a large family (which thus costs more to insure) or is elderly were discharged or denied a job, he or she could sue the employer under the anti-discrimination provisions of S. 1227 and collect damages, including health care costs and possible stiff fines.

Just as under civil rights legislation, the pattern of hiring of every firm would come under scrutiny. If a company's work force were in general younger or more healthy than the population in the area, and it had chosen to provide its workers with health insurance, the firm could find itself embroiled in lawsuits alleging discrimination. Employers could avoid this costly quagmire of lawsuits, of course, simply by dropping private coverage and dumping their workers into Americare.

If employers paying the payroll tax lobbied Congress successfully to prevent the Americare tax rate from increasing in future years, and thus hold down their health care costs while the cost of private coverage increased, there would be a steady increase in the number of employers choosing the Americare option. As a result, the difference between the Americare tax and the true cost of the coverage would increase and require larger infusions of general tax revenues.

Thus under S. 1227, the majority of non-elderly Americans would be forced into the public Americare system, which essentially would become a massive Medicaid program. The broad middle class consequently would lose its current private insurance coverage and be consigned to a government-directed system with Medicaid levels of coverage and quality.

CONTROLLING COSTS BY DESTROYING QUALITY

In testimony before the House Budget Committee last July 24, Mitchell identified what was rapidly driving up the costs of American health care. He said:

Many years ago, not by any grand plan or design to meet what was, in fact, an unmet need in our society, we began a process which has resulted in the separation of payment for health care from the receipt of health care services. That has met, to some

degree, what was an unmet need; but it has, at the same time, created over-utilization and a problem of attitude with respect to the quantity of health care.

What Mitchell meant was that because so-called "third parties"—companies or the government—usually pay the bills, the payment for health care is not a direct concern of the consumer. Consequently, the consumer will demand ever more health care with little or no regard for expense. With the consumer unconcerned about costs, the physician or hospital is not concerned either. The result: rapidly escalating costs.

In this arrangement, providers of health care have little incentive to become more efficient. Indeed, efficient or productive providers actually are penalized with decreased income because value-for-money does not attract customers if those customers are unconcerned about the bill. Conversely, those providers who dispense more services regardless of their actual benefit, or charge higher prices, are rewarded with increased incomes.

Reversing Backward Incentives. The key to health care reform lies in reversing these backward incentives. But this will happen only when the consumers who demand health care also pay directly for medical services and insurance.

Although Mitchell apparently recognizes the problem, his proposed Health-America Act does nothing to address the separation of payment for health care from the receipt of services. To the contrary, the bill would extend and perpetuate the relationship at the root of the health care problem. Indeed, the third-party payment system would be further entrenched as a result of the bill's coverage mandates.

The employers who now finance most private third-party coverage, moreover, would lose most of whatever incentives and powers they now have to control costs. Many employers would abandon their current efforts to control costs and simply turn over their employees to the public program. Those choosing to continue coverage would find their ability to control costs weakened because there would be a national minimum for health benefits package. Worse still, this minimum package of benefits undoubtedly would rise substantially in cost over time, since if organized labor could not persuade companies to increase benefits at the negotiating table, unions would have the incentive to lobby Congress to raise the minimum benefits.

AN OLD-STYLE CENTRAL PLANNING NIGHTMARE

The Mitchell bill does not try to address the cost escalation by introducing incentives for consumers to consider value for money in insurance or medical services. Instead, the bill in effect rejects the market approach entirely and tries instead to control costs by establishing a sweeping, central planning bureaucracy to run the entire U.S. health care system, including the privately insured sector. The bill is extraordinarily ambitious in the scope and rigor with which it would remove every remaining aspect of normal market functions and replace them with a vast central planning apparatus. The Mitchell bill, in short, would turn over

about one-eighth of the American economy now spent on health care (over \$700 billion) to the kind of central planning now being abandoned around the world.

Regulatory Nightmare. The central planning system envisioned by the Mitchell bill would dwarf in complexity and scope those found in the national health systems of other Western countries. Government regulation of health care spending and services in Britain, Canada, or Sweden, for example, actually is quite crude and simple compared with the apparatus proposed by S. 1227. Even so, these nations have not escaped the inevitable shortcomings of central planning: shortages, rationing, and waiting lists. Indeed, Britain and Sweden now are seeking to introduce market-based mechanisms in a desperate effort to deal with the serious problems facing their health systems.

Ignoring the accumulated weight of evidence detailing the failure of central planning in health care or elsewhere, the Mitchell bill would establish a Federal Health Expenditure Board to set annual health expenditure limits for the entire country, with quotas for each state and health care sector. The Board would convene planning committees consisting of supposed representatives of health care providers and consumers to negotiate terms and conditions for health care delivery and payment throughout the nation. Thus, instead of the normal market incentives and competition that assure quality and price restraint in the rest of the economy, the Mitchell bill counts on an all-powerful planning board to accomplish this task.

Adding yet another layer to this bureaucratic structure, each state would be required to establish a Quality Improvement Board. These boards essentially would set "guidelines" for medical practices and procedures in their respective states. Such guidelines, of course, likely would be mandatory, given the central dictation of fees and direction of resources. Instead of consumers determining what services they want and what price and quality they consider acceptable, government boards and agencies would issue pronouncements on what services are worthwhile and what constitutes good value.

Limits Make No Sense. While some policy makers in health care are fascinated by the idea of national expenditure limits, most economists recognize they make no sense. A national board and its various committees have no way of knowing what total health expenditures in America or a state "should be." The correct amount of such expenditures can only be determined through the decentralized market process based on millions of choices made by individuals faced with competing providers.

Expenditure limits set by a national board can only be arbitrary, and if they are lower than the amount that consumers want to spend, the result inevitably is shortages. This means that some Americans will be denied care. This is true whether the central planning committees are composed of ostensible representatives of interest groups, government officials, and academic experts, or whether individuals are picked at random from a phone book. Indeed, populating the committees with representatives of interest groups as S. 1227 would do, would give most power to well-organized special interest groups and least to ordinary Americans.

HOW QUALITY WOULD SUFFER

The bill's central planning regime would reduce the high quality of health care now enjoyed by the average American. As in the British, Canadian, or other nationalized health systems, the bill's proposed expenditure limits would restrict resources devoted to medical care, forcing providers to ration care. In particular, the expenditure limits and restrictions on capital investment envisioned in the bill would limit and delay the purchase of technologically advanced equipment, and the maintenance and expansion of facilities. Such limits in Canada have slowed significantly the rate of introduction and the availability of new technology.

Under the Mitchell bill, there would not only be a financial restriction on new technology, but developers of new equipment first would have to convince technology assessors and outcome measurers at the Federal Health Expenditure Board, state Quality Improvement Boards, and the Public Health Service that the innovation was worthwhile. Then the innovator would have to persuade the Federal Board and numerous state and specialty committees to approve compensation levels to physicians and hospitals operating the new technology.

These bureaucrats would have no economic incentive to ensure quality improvement; their top priority would be to avoid new costs in order to meet the system's expenditure limits.

For the great majority of workers, locked into Americare, quality would be further threatened by the fee schedule in the program. States no doubt would exercise their authority under the bill to use the Medicaid reimbursement rates for the first six years under Americare, as permitted under the bill, because these rates are so much lower than the Medicare rates seen by the bill's sponsors as the eventual basis for Americare payments to physicians and hospitals. Because of the low fee rates under Medicaid, the services generally are of the lower quality than under today's private plans.

The current American medical system provides the average insured worker or family member with routine access to higher quality and more sophisticated care than anywhere in the world. The HealthAmerica Act would systematically undermine this high quality of care for the average family.

THE MOST IMPORTANT EMPLOYEE BENEFIT—A JOB

The primary aim of the Mitchell bill is not to control costs, but to extend coverage to Americans who today have no health insurance. Yet these very individuals would find their jobs threatened under the bill.

The uninsured tend to be workers, or the dependents of workers, in small and start-up firms. These firms find it hard to afford insurance because they lack the number of workers needed to obtain a good insurance rate and because many small firms could not be profitable if they offered generous health benefits.

Adding to Unemployment. If the owners of these small and new businesses are forced to pay a new tax on their workers or provide insurance, many would have to cut their work force or go out of business.¹⁰ The bill consequently would mean that many of the uninsured would lose their jobs.

Employers could offset the added costs of the newly mandated insurance or payroll tax by reducing the wages of the currently uninsured. When this happens, the uninsured would benefit little from the bill, as they in effect would be paying for the insurance themselves. Given the minimum benefit package required by the bill, moreover, many of these workers would be forced to buy more insurance than they would choose or need. And if the Americare tax rate were increased to cover more of the program's costs, this would only add to the heavy financial burden on the uninsured or increase job losses.

The Mitchell bill meanwhile would affect some of the insured differently from others, and thus encourage changes in hiring patterns. Example: one way that employers could reduce their costs under the bill would be to use part-time rather than full-time workers. Part-time workers would be required to pay 50 percent of the premium cost, rather than only 20 percent of the premiums. Employers might well recast many currently insured full-time workers as part-time workers to reduce the cost of raising benefit levels to the required minimum.

HOW TO GET MORE FOR LESS

There are only two ways to reduce health care costs—or indeed the cost of any good or service. The first is to get “less for less.” That is, to spend less by accepting less—less quality, less service, less technology, less benefits, less access.

The other way is “more for less.” That is, to increase productivity so that less spending will buy more—more quality, more services, more technology, more benefits, and more access.

Adopting “less for less” is how every centrally planned nationalized health system in the world attempts to control costs. It is also how S. 1227 would attempt to control costs.

Obtaining more health care for less money can only be achieved through productivity increases in the delivery of medical care, which in turn, can only result from a normal market in which consumers have the incentive to choose the best value for money and in which providers who increase productivity are rewarded.

¹⁰ Since the great majority of the uninsured are likely to be in firms with average per employee payrolls of less than \$51,000 per year, they are likely to be covered by Americare rather than private insurance, as discussed above. The proposed small business tax credit consequently would have little or no effect in ameliorating these negative employment impacts. The bill's proposed exemption from the insurance mandate for small businesses implies recognition by the sponsors that the employment impact of the insurance mandate on small businesses would be a problem. Yet the exemption would only mean a delay in layoffs.

Forcing an employer to "pay" for an employee-family's health care is simply a hidden way, moreover, of making the employee pay for his or her own care, since the employer includes the cost of health care as part of the total compensation for the worker—which is determined by the market for labor. More health benefits ultimately means less cash wages. Thus, if some Americans cannot afford care, the proper policy is to help them directly to pay for it, not to adopt the illusion that an employer can be forced to pay.

Consumer Choice Needed. Only a sound, freely functioning market will reward the more productive (high quality, low cost) providers with more patients, and thus, higher incomes. A sound, freely functioning health care market will exist only when consumers directly purchase their own medical care and health insurance, and are thus rewarded with better health and savings in their pockets for buying from more productive providers. And only a change in the way that the government subsidizes Americans to buy health care and health insurance will enable lower-paid Americans to afford care—rather than simply forcing these workers to accept health insurance paid for with lower wages.

The Mitchell HealthAmerica bill will not create a consumer choice market in health care and thus does not offer Americans more for less. It offers, as do nationalized health systems, less for less. In place of the Mitchell bill, Congress should consider reform proposals which would introduce consumer-choice market incentives into health care. Such a consumer choice health plan has been proposed by Heritage Foundation scholars.¹¹ The key elements of such a reform are:

- ☞ Consumers must be given control over the money spent on their health care and the power to decide how best to spend it;
- ☞ All Americans must receive, through the tax code, an equal incentive to purchase needed medical care and health insurance in whatever manner, or from whomever, they choose;
- ☞ All Americans thus will have health care;
- ☞ The tax code and public programs must be further reformed so that tax-based assistance to Americans with low incomes or high medical costs is sufficient to increase their purchasing power in the medical marketplace so that they can afford the care and insurance they need. Simultaneously, the structure of tax assistance to other Americans must be changed to encourage them to seek better value for money rather than, as today, heavily subsidizing generous health plans for high-income Americans.

¹¹ See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); Stuart M. Butler, "Using Tax Credits to Create an Affordable Health System," Heritage Foundation *Background* No. 77, July 20, 1990; Stuart M. Butler, "A Tax Reform Strategy to Deal With the Uninsured," *The Journal of the American Medical Association*, Volume 265, May 15, 1991.

By giving health care funds and health care tax relief to Americans directly, instead of indirectly through company-based plans, workers and their families would have a much wider choice of health care packages. By being able to choose a health plan from a source other than their place of work, their health care would be separate from their employment. No longer would a change of job mean a change of benefits or, worse still, the loss of benefits. No longer would losing a job mean losing health benefits.

CONCLUSION

The HealthAmerica Act has been touted as a compromise between America's current health care system and a Canadian-style government-run national health care. It is nothing of the sort.

The incentives created by the Mitchell bill mean that the play or pay system quickly would collapse into a full-blown, government-run, taxpayer-financed, national health care system, with all the features of such systems that would be unacceptable to most Americans—long waiting lines for care, explicit rationing of care, and limits on a patient's choice of doctor and treatment.

The play or pay model of health care reform is, in short, a political bait and switch. The bait is the notion of building on today's employment-based system. The switch is a super-Medicaid program that few Americans want. Significantly, congressmen have made sure in the bill that they would not be included in the system they tout as best for other Americans.

Market Incentives. What is needed instead is a consumer-choice, universal health care system. Such a system would create market incentives to increase productivity in the health care delivery system by simultaneously cutting costs and boosting quality and effectiveness. This is the system that works in the rest of America's economy, and by changing the current perverse incentives in the employment-based system it would work in health care. The result would be an American health care system that offered Americans the best health care value for their money. Such an achievement would be the envy of the world.

Edmund F. Haislmaier
Policy Analyst

All Heritage Foundation papers are now available electronically to subscribers of the "NEXIS" on-line data retrieval service. The Heritage Foundation's Reports (HFRPTS) can be found in the OMNI, CURRNT, NWLTRS, and GVT group files of the NEXIS library and in the GOVT and OMNI group files of the GOVNWS library.

Health

Document Originally
Attached to
Following Page

7/17

Clifford M. Sobel
40 Dorison Drive
Short Hills, New Jersey 07078

July 13, 1992

Ms. Gail Wilensky
Deputy Assistant to the President
for Foreign Policy
The White House
1600 Pennsylvania Ave., N.W.
Washington, D.C. 20005

Dear Gail:

Enclosed please find the overview I discussed during your quickly arranged trip to New York with the Vice President in May.

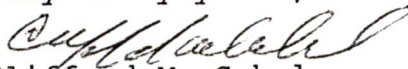
A lot has happened since then, as a matter of fact, I was with the Vice President when he came to New York and New Jersey in June (it was not one of his more memorable trips).

As I indicated to you previously, (if you recall) I had arranged for our New Jersey Medical Society to meet with Richard Porter's staff earlier in the year. Instead of sending you the full blown draft of their proposal I asked Dr. Hank Rosen to give an overview, which can be more easily read.

I am also sending a copy to Richard Porter of the Vice Presidents staff who expressed interest in seeing it. Hank Rosen has been very supportive of the Republican Party in New Jersey and has taken an active leadership roll in working with me on numerous events so I would appreciate some acknowledgment from your office as to receipt of this letter. If there is any interest in pursuing this matter, you can call him directly.

I am sure I will be seeing you soon. One last point, I would like to recommend during your next trip to Vail you stay in Vail Village not Lionshead.

Very truly yours,


Clifford M. Sobel

CMS/md

cc: Richard Porter ✓

NORTHERN JERSEY EAR, NOSE AND THROAT ASSOCIATES

RIDGEWOOD OTOLARYNGOLOGY ASSOCIATES

44 GODWIN AVENUE

MIDLAND PARK, NEW JERSEY 07432

(201) 445-2900 FAX (201) 445-8679

JOEL F. LEHRER, M.D.
DONALD J. NALEBUFF, M.D.
HENRY D. ROSIN, M.D.
JERRY SILVER, M.D.

ASMAT V. QURAISH, M.D.
HARRY KATZ, M.D.
JASON B. SUROW, M.D.
ORRIN DAVIS, M.D.

May 28, 1992

Ms. Gail Wilensky
Deputy Assistant to the President
for Policy Development
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20005

Dear Ms. Wilensky,

Cliff Sobel asked me to send you a summary of our ideas about Health Care. Following this summary, I will send a draft of proposals suggested by our group of northern New Jersey physicians. These proposals initially envisioned a demonstration project in New Jersey, and sought to identify areas of reform. A number of illustrative "solutions" were described in the text. The New Jersey State Medical Society formed a committee to study our plan, as well as those embodied in the AMA's "Health Access America" program. After meetings with our committee, State Legislators are introducing legislation creating a "New Jersey Legislative Commission on Health Care Financing". A team of physicians approved by the New Jersey Medical Society, including representatives of our northern New Jersey group, will be members of the Commission, the first part of which will be heavily weighted with medical/hospital/pharmaceutical representatives as well as members of the New Jersey Senate and Assembly. Later, community discussion and input will be sought.

I believe that a synthesis of our plan and that of the AMA, together with additional ideas from the other non-physician members of the Commission, will produce a final plan by professional people to deal with the cost/access problems which must be controlled.

The plan which follows, then, is really a compendium of ideas from one group of intensely concerned physicians. We understand that there are major problems in implementing it as is, so expect many modifications by the State Commission.

However, the proposals do include ideas which the Federal administration might find worthy of consideration in conjunction with our State Commission.

Our plan would create a New Jersey Health Authority (described in the body of the program as the "consortium"), which would monitor and assist in implementation of the program.

It is obvious that the plan must include a mechanism for Federal cooperation with the "Authority".

We believe that no State plan can succeed without changes in Federal programs. The plan has been reviewed by the State Legislative Services Committee; this point was strongly made. We are aware of the President's call for State Experiments, and of the many States which have responded. Since, however, so much of the health care dollar is expended by the Federal government, we believe that only a State-Federal cooperative effort will ultimately succeed in creating a American solution.

We have carefully studied the many foreign models, and believe that American society does not lend itself to fit other health-care delivery molds.

Fundamental to our proposal is the notion that the ideas of Medical Professionals can represent a major part of the solution of our problems. Most efforts at cost-control have focused on regulating physicians and hospitals. The average dedicated, ethical physician has been degraded and demoralized by government, insurance companies, and others, to the point where the practice of medicine has become subservient to harassment from every direction. Destroying the income of physicians who have spent eleven to fifteen years training for their profession, and whose responsibilities and stresses rival those of any other professionals, is likely to destroy private practice and the personal relationships we have had with patients. Recent HCFA regulations are already having this effect. Unless we can find a solution to our problems which does not destroy private practice, the future of medical care in the United States will surely be cheaper, and equally surely, much worse. Excessive regulation will work no better here than in eastern Europe.

Our concept is to restore responsibility to the health care community -- not by regulation and hassle -- but by self interest. Further, we do not believe in rationing of care, and we do believe that the eight hundred billion dollars spent on health care is more than enough to provide excellent care to everyone.

Our program includes ideas which would:

1. Reduce the cost of insurance in the first instance by eliminating or greatly reducing profit for health insurance, and by reducing the blatant inefficiencies of this "system".

2. Reduce hospital and nursing home cost by de-regulation, by monitoring the actions of administrators, by reducing the "amenities" of hospitalization, by combining hospital and nursing home units, and by permitting expansion and equipment purchase if the institution earns the money to do so.

3. Create a profit-sharing mechanism by combining single or multiple hospitals in areas of wealth with those in poverty areas, so that a percentage of the profits to be used for improvements in the former would be given to the latter for their use.

4. Regulate physicians' fees within realistic ranges through a physician-managed insurance company, in order to permit the continuation of the private practice environment.

5. Require that medical internships be rotating, and emphasize Family Practice, and further require that all licensed physicians after internship, and licensed foreign physicians entering the country, join a "Medical Service Corps" and give one year toward care of the poor. A structure would also be created for donation of time by practicing physicians, and for other methods of improving access to care in poverty areas.

6. Reform Medical Malpractice by offering apparently injured patients either a reformed current tort type of system or a new system of immediate adjudication, set recompense for injury, and medical measures to improve the knowledge and/or ability of erring physicians.

7. Improve the mechanism of employer/employee purchase of medical insurance as described in the program.

8. Eliminate the "uncompensated care" patient, most of whom are working people or children, by placing them in the care of the Medical Service Corps or, by reducing costs of insurance and improving employer assistance, return them to the ranks of the insured.

9. Create a dialogue between the insurance company, the medical appliance and pharmaceutical industries, the physicians, the hospitals, and the Legislature. A relationship should be established between the cost of Research and Development, profitability of the company, and cost to the public of

pharmaceuticals. Pharmaceutical companies, we believe, will find it in their best interests to reduce costs when those who prescribe and use their products are in the discussion, and when the Legislature is involved. The role of generic drug companies and R & D will be addressed.

10. Greatly improve access to care, and preventive medicine of every kind, to the poor. Medicaid should be structurally changed from its current role in bill payment for physicians and hospitals functioning in a private practice mode. Substitution of "private practice" methodology and expense for the MSC should accomplish this. Reductions in hospital nursing home expenses should reduce costs as has been described. Bringing hospital fixed and mobile "clinics" to the people should improve access. We do not feel that major cost reduction will occur with relation to our current Medicaid population without major societal improvements, but at least decent care and sufficient physicians should be available for this desperate segment of our population.

Medicare patients should receive assistance when needed, but it is unfair for young people, with all their needs, to subsidize care of those elderly people who can afford private insurance. We believe 10-15% of the Medicare population is in this situation, and since Medicare patients use over 40% of hospital beds and visits to internists' offices, a great deal of care is being subsidized by the young population. We also believe that insurance for older people would be cheaper if the role of the Federal Government were solely to buy an insurance policy from a non-profit low overhead insurance company and leave oversight responsibility to the company and its' physicians.

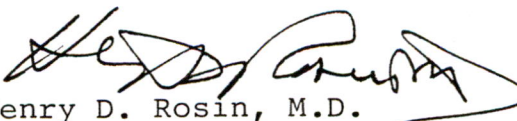
11. Bring societal issues to the public. Our experience as practicing physicians mirrors that presented in both scientific studies and the media. The cost of treating the comatose, the very premature, and the very old are important factors differentiating the cost of health care for Americans from that of the rest of the world. Further, crime, AIDS, and addiction create massive health care costs unique in their magnitude to the United States. Society itself must become aware of all this and of the costs involved. The health care industry is blamed almost exclusively for costs. It is time to tell the people some hard truths -- and to force these issues on economic as well as humanitarian terms.

12. Provide a color-coded health care credit card to every American citizen, which would be issued by the Authority or other authorized agency, which would guarantee care to all, and provide reasonable reimbursement at various levels.

We believe that a cooperative effort by Medical Professionals of all kinds, and the State and Federal Governments, may be capable of attacking the root causes of our two fundamental problems -- cost and access. The time has come for such an effort.

I look forward to discussing all this with you if you feel we have something to contribute. We present these ideas because we are concerned with the future. I hope you find them interesting, at least as a beginning. We are convinced that no amount of alteration in any single part of the health care system will solve the access and cost problems. Everything must be on the table, and then, we think, there will be hope.

Sincerely,



Henry D. Rosin, M.D.

Clifford M. Sobel
40 Dorison Drive
Short Hills, New Jersey 07078

July 13, 1992

Ms. Gail Wilensky
Deputy Assistant to the President
for Foreign Policy
The White House
1600 Pennsylvania Ave., N.W.
Washington, D.C. 20005

Dear Gail:

Enclosed please find the overview I discussed during your quickly arranged trip to New York with the Vice President in May.

A lot has happened since then, as a matter of fact, I was with the Vice President when he came to New York and New Jersey in June (it was not one of his more memorable trips).

As I indicated to you previously, (if you recall) I had arranged for our New Jersey Medical Society to meet with Richard Porter's staff earlier in the year. Instead of sending you the full blown draft of their proposal I asked Dr. Hank Rosen to give an overview, which can be more easily read.

I am also sending a copy to Richard Porter of the Vice Presidents staff who expressed interest in seeing it. Hank Rosen has been very supportive of the Republican Party in New Jersey and has taken an active leadership roll in working with me on numerous events so I would appreciate some acknowledgment from your office as to receipt of this letter. If there is any interest in pursuing this matter, you can call him directly.

I am sure I will be seeing you soon. One last point, I would like to recommend during your next trip to Vail you stay in Vail Village not Lionshead.

Very truly yours,

Clifford M. Sobel
Clifford M. Sobel

CMS/md
cc: Richard Porter

NORTHERN JERSEY EAR, NOSE AND THROAT ASSOCIATES

RIDGEWOOD OTOLARYNGOLOGY ASSOCIATES

44 GODWIN AVENUE

MIDLAND PARK, NEW JERSEY 07432

(201) 445-2900 FAX (201) 445-8679

JOEL F. LEHRER, M.D.
DONALD J. NALEBUFF, M.D.
HENRY D. ROSIN, M.D.
JERRY SILVER, M.D.

ASMAT V. QURAISH, M.D.
HARRY KATZ, M.D.
JASON B. SUROW, M.D.
ORRIN DAVIS, M.D.

May 28, 1992

Ms. Gail Wilensky
Deputy Assistant to the President
for Policy Development
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20005

Dear Ms. Wilensky,

Cliff Sobel asked me to send you a summary of our ideas about Health Care. Following this summary, I will send a draft of proposals suggested by our group of northern New Jersey physicians. These proposals initially envisioned a demonstration project in New Jersey, and sought to identify areas of reform. A number of illustrative "solutions" were described in the text. The New Jersey State Medical Society formed a committee to study our plan, as well as those embodied in the AMA's "Health Access America" program. After meetings with our committee, State Legislators are introducing legislation creating a "New Jersey Legislative Commission on Health Care Financing". A team of physicians approved by the New Jersey Medical Society, including representatives of our northern New Jersey group, will be members of the Commission, the first part of which will be heavily weighted with medical/hospital/pharmaceutical representatives as well as members of the New Jersey Senate and Assembly. Later, community discussion and input will be sought.

I believe that a synthesis of our plan and that of the AMA, together with additional ideas from the other non-physician members of the Commission, will produce a final plan by professional people to deal with the cost/access problems which must be controlled.

The plan which follows, then, is really a compendium of ideas from one group of intensely concerned physicians. We understand that there are major problems in implementing it as is, so expect many modifications by the State Commission.

However, the proposals do include ideas which the Federal administration might find worthy of consideration in conjunction with our State Commission.

Our plan would create a New Jersey Health Authority (described in the body of the program as the "consortium"), which would monitor and assist in implementation of the program.

It is obvious that the plan must include a mechanism for Federal cooperation with the "Authority".

We believe that no State plan can succeed without changes in Federal programs. The plan has been reviewed by the State Legislative Services Committee; this point was strongly made. We are aware of the President's call for State Experiments, and of the many States which have responded. Since, however, so much of the health care dollar is expended by the Federal government, we believe that only a State-Federal cooperative effort will ultimately succeed in creating a American solution.

We have carefully studied the many foreign models, and believe that American society does not lend itself to fit other health-care delivery molds.

Fundamental to our proposal is the notion that the ideas of Medical Professionals can represent a major part of the solution of our problems. Most efforts at cost-control have focused on regulating physicians and hospitals. The average dedicated, ethical physician has been degraded and demoralized by government, insurance companies, and others, to the point where the practice of medicine has become subservient to harassment from every direction. Destroying the income of physicians who have spent eleven to fifteen years training for their profession, and whose responsibilities and stresses rival those of any other professionals, is likely to destroy private practice and the personal relationships we have had with patients. Recent HCFA regulations are already having this effect. Unless we can find a solution to our problems which does not destroy private practice, the future of medical care in the United States will surely be cheaper, and equally surely, much worse. Excessive regulation will work no better here than in eastern Europe.

Our concept is to restore responsibility to the health care community -- not by regulation and hassle -- but by self interest. Further, we do not believe in rationing of care, and we do believe that the eight hundred billion dollars spent on health care is more than enough to provide excellent care to everyone.

Our program includes ideas which would:

1. Reduce the cost of insurance in the first instance by eliminating or greatly reducing profit for health insurance, and by reducing the blatant inefficiencies of this "system".

2. Reduce hospital and nursing home cost by de-regulation, by monitoring the actions of administrators, by reducing the "amenities" of hospitalization, by combining hospital and nursing home units, and by permitting expansion and equipment purchase if the institution earns the money to do so.

3. Create a profit-sharing mechanism by combining single or multiple hospitals in areas of wealth with those in poverty areas, so that a percentage of the profits to be used for improvements in the former would be given to the latter for their use.

4. Regulate physicians' fees within realistic ranges through a physician-managed insurance company, in order to permit the continuation of the private practice environment.

5. Require that medical internships be rotating, and emphasize Family Practice, and further require that all licensed physicians after internship, and licensed foreign physicians entering the country, join a "Medical Service Corps" and give one year toward care of the poor. A structure would also be created for donation of time by practicing physicians, and for other methods of improving access to care in poverty areas.

6. Reform Medical Malpractice by offering apparently injured patients either a reformed current tort type of system or a new system of immediate adjudication, set recompense for injury, and medical measures to improve the knowledge and/or ability of erring physicians.

7. Improve the mechanism of employer/employee purchase of medical insurance as described in the program.

8. Eliminate the "uncompensated care" patient, most of whom are working people or children, by placing them in the care of the Medical Service Corps or, by reducing costs of insurance and improving employer assistance, return them to the ranks of the insured.

9. Create a dialogue between the insurance company, the medical appliance and pharmaceutical industries, the physicians, the hospitals, and the Legislature. A relationship should be established between the cost of Research and Development, profitability of the company, and cost to the public of

pharmaceuticals. Pharmaceutical companies, we believe, will find it in their best interests to reduce costs when those who prescribe and use their products are in the discussion, and when the Legislature is involved. The role of generic drug companies and R & D will be addressed.

10. Greatly improve access to care, and preventive medicine of every kind, to the poor. Medicaid should be structurally changed from its current role in bill payment for physicians and hospitals functioning in a private practice mode. Substitution of "private practice" methodology and expense for the MSC should accomplish this. Reductions in hospital nursing home expenses should reduce costs as has been described. Bringing hospital fixed and mobile "clinics" to the people should improve access. We do not feel that major cost reduction will occur with relation to our current Medicaid population without major societal improvements, but at least decent care and sufficient physicians should be available for this desperate segment of our population.

Medicare patients should receive assistance when needed, but it is unfair for young people, with all their needs, to subsidize care of those elderly people who can afford private insurance. We believe 10-15% of the Medicare population is in this situation, and since Medicare patients use over 40% of hospital beds and visits to internists' offices, a great deal of care is being subsidized by the young population. We also believe that insurance for older people would be cheaper if the role of the Federal Government were solely to buy an insurance policy from a non-profit low overhead insurance company and leave oversight responsibility to the company and its' physicians.

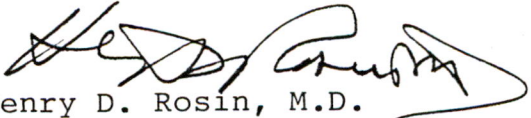
11. Bring societal issues to the public. Our experience as practicing physicians mirrors that presented in both scientific studies and the media. The cost of treating the comatose, the very premature, and the very old are important factors differentiating the cost of health care for Americans from that of the rest of the world. Further, crime, AIDS, and addiction create massive health care costs unique in their magnitude to the United States. Society itself must become aware of all this and of the costs involved. The health care industry is blamed almost exclusively for costs. It is time to tell the people some hard truths -- and to force these issues on economic as well as humanitarian terms.

12. Provide a color-coded health care credit card to every American citizen, which would be issued by the Authority or other authorized agency, which would guarantee care to all, and provide reasonable reimbursement at various levels.

We believe that a cooperative effort by Medical Professionals of all kinds, and the State and Federal Governments, may be capable of attacking the root causes of our two fundamental problems -- cost and access. The time has come for such an effort.

I look forward to discussing all this with you if you feel we have something to contribute. We present these ideas because we are concerned with the future. I hope you find them interesting, at least as a beginning. We are convinced that no amount of alteration in any single part of the health care system will solve the access and cost problems. Everything must be on the table, and then, we think, there will be hope.

Sincerely,



Henry D. Rosin, M.D.

File:

Health Care: International
Comparisons

Document Originally
Attached to
Following Page

HEALTH CARE SYSTEMS IN TWENTY-FOUR COUNTRIES

by George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald

Prologue: Changes in the way health care systems finance services are often driven by some combination of data, public pressure, payer receptivity, and the expressed views of the medical profession and allied disciplines. In this paper, two of the most seasoned observers of comparative health system research and a colleague provide the latest data and some commentary upon them for the health care enterprises of the twenty-four countries that are members of the Organization for Economic Cooperation and Development (OECD). George Schieber is director of the Office of Research at the U.S. Health Care Financing Administration (HCFA). Jean-Pierre Poullier is principal administrator, Directorate for Social Affairs, Manpower, and Education for the OECD in Paris. Leslie Greenwald is a health policy analyst in the HCFA Office of Research and also a doctoral candidate in public policy at the University of Virginia. The OECD's health database provides the most current road map available to compare the status of the health systems of its member states. Given that these twenty-four member countries spend on average almost 8 percent of their gross domestic product on financing health care services, it seems remarkable that the OECD devotes so few of its resources to tracking trends in these health systems. Poullier is an incredibly valuable resource in the collection and analysis of these data, given that he essentially works alone keeping tabs on how twenty-four countries are allocating their health resources. While the OECD's effort in tracking health financing data is far from sufficient, it exceeds comparable pursuits at the World Health Organization and the European Community, where health financing issues enjoy even less standing.

In comparison with other major industrialized countries, health care in the United States costs more per person and per unit of service, is less accessible to a large portion of its citizens, is provided at a more intensive level, and offers comparatively poor gross outcomes. This article examines the latest numbers behind the financing and delivery of health care in the United States and twenty-three other member countries of the Organization for Economic Cooperation and Development (OECD). In this analysis, we present and analyze new information from the OECD database on acute care hospital availability, use, and expenditures; physician availability and expenditures; and pharmaceutical expenditures. The article is based on the forthcoming OECD publication *OECD Health Systems: Facts and Trends*, which will contain over 200 tables of comparative data and be available in an integrated computer software package, *Eco-Sante OCDE/OECD Health Data*.

Health Expenditures

Exhibit 1 contains information on health expenditures for the twenty-four OECD countries in 1989. In particular, information on the health-to-GDP ratios and per capita health spending (in U.S. dollars) that was presented in *Health Affairs*, Spring 1991, are reproduced here, along with the 1989 public share of total health spending.¹ The health expenditure figures for Australia have been revised upward on the order of 10 percent because of the more appropriate attribution of expenditure information to previous years, and new data for Turkey have been added.² As was reported in *Health Affairs*, Spring 1991, U.S. spending—whether measured by gross domestic product (GDP) shares or per capita in U.S. dollars—far exceeded spending levels in other industrialized countries. In particular, 1989 U.S. per capita spending of \$2,354 was over double the twenty-four-country \$1,059 OECD average, and the U.S. share of GDP devoted to health of 11.8 percent was 60 percent above the 7.4 percent OECD average. Exhibit 2 displays U.S. per capita health spending and the percentage by which it exceeds spending in other countries.

In the relationship between per capita health spending and per capita GDP, once again, U.S. spending lies well above the trend line (Exhibit 3). In fact, the United States appears to be moving further above the trend line as time goes on. For example, in 1987, U.S. spending was estimated to be \$450 above the trend line, while in 1989, it is estimated to be almost \$600 above the line.³ This is consistent with previously reported results of other countries' relative success in moderating health spending. Very preliminary 1990 estimates suggest that the U.S. health-to-GDP ratio increased by half a percentage point to 12.3 percent, while

Exhibit 1
Health Care Expenditures In Twenty-Four OECD Countries, 1989

	Percent of GDP ^a	Percent public spending	Per capita health spending ^b
Australia	7.6%	70%	\$1,125
Austria	8.2	67	1,093
Belgium	7.2	89	980
Canada	8.7	75	1,683
Denmark	6.3	84	912
Finland	7.1	79	1,067
France	8.7	75	1,274
Germany	8.2	72	1,232
Greece	5.1	89	371
Iceland	8.6	88	1,353
Ireland	7.3	84	658
Italy	7.6	79	1,050
Japan	6.7	73	1,035
Luxembourg	7.4	92	1,193
Netherlands	8.3	73	1,135
New Zealand	7.1	85	820
Norway	7.6	95	1,234
Portugal	6.3	62	464
Spain	6.3	78	644
Sweden	8.8	90	1,361
Switzerland	7.8	68	1,376
Turkey	3.9	37	175
United Kingdom	5.8	87	836
United States	11.8	42	2,354
Average	7.4	76	\$1,059

Source: G. J. Schieber and J. P. Poullier, "International Health Spending: Issues and Trends," *Health Affairs* (Spring 1991): 106-116; and OECD Health Data, 1991.

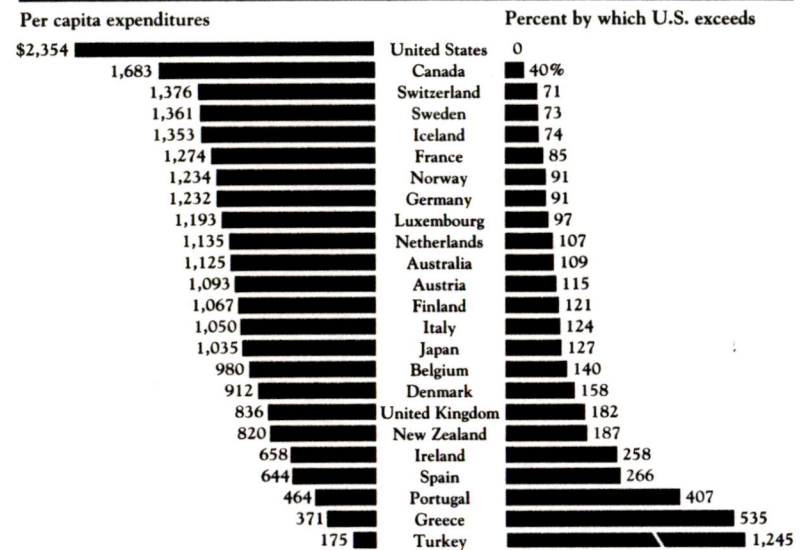
^a Gross domestic product.

^b In U.S. dollars, gross domestic product purchasing power parities.

the OECD average remained stable. The largest increase in a health-to-GDP ratio for a major U.S. trading partner is estimated to be no more than half of the U.S. increase.

The new 1989 information presented on the percent of total health spending accounted for by the public sector is similar to the 1987 figures reported in *Health Affairs*, Fall 1989, although the series for a few countries have been revised to improve their comparability and comprehensiveness. For example, Germany and Italy have slightly lower public shares because of the inclusion of better information on private investment.⁴ The United States is the only country besides Turkey in which public spending is less than half of the total. Public shares ranged from 37 percent in Turkey and 42 percent in the United States to 95 percent in Norway, with an OECD average of 76 percent.

Exhibit 2
Per Capita Health Spending In Twenty-Four OECD Countries, 1989



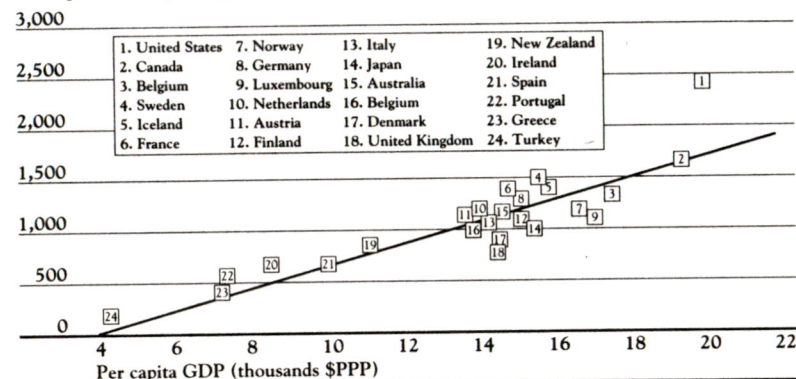
Sources: G. J. Schieber and J. P. Poullier, "International Health Spending: Issues and Trends," *Health Affairs* (Spring 1991): 106-116; and OECD Health Data, 1991.

Availability And Use Of Medical Care Services

Ideally, health care financing and delivery systems would be described on the basis of a standard taxonomy, which provides detailed qualitative information on the eligibility, benefits, reimbursement, financing, and delivery system characteristics, as well as quantitative measures of the availability and use of specific health services based on standard definitions. Unfortunately, despite some notable attempts in these directions, no such taxonomy has been developed, and there are no internationally accepted definitions of specific inpatient and outpatient services that lead to the desired level of standardization for comparisons of the highly developed health systems of the OECD countries.⁵ The ability to develop such a system for inpatient hospitals is further complicated by the manner in which the administrative reporting systems of different countries maintain information and by the ambiguity of the boundary between acute and long-term care. As a result of these problems, the OECD Secretariat has collated data following ad hoc guidelines. Thus, inpatient

Exhibit 3
Per Capita Health Spending And Per Capita Gross Domestic Product (GDP) In Twenty-Four OECD Countries, 1989

Per capita health spending (\$PPP)^a



Sources: G.J. Schieber and J.P. Poullier, "International Health Spending: Issues and Trends," *Health Affairs* (Spring 1991): 106-116; and OECD Health Data, 1991.

Note: PCH=per capita health spending. PCGDP=per capita gross domestic product. $PCH = -419 + .107 \times PCGDP$. Both the constant term and the regression coefficient are statistically significant at the .01 level. $R^2 = .85$ (adjusted correlation coefficient squared; also significant at the .01 level).

^aPurchasing power parities.

medical care applies to institutions whose principal purpose is medical, not geriatric custodial, care. Inpatient stays apply only to patients remaining overnight. There are still many interpretations of these crude guidelines and of the classification of certain facilities as medical or custodial.⁶

Inpatient medical care. Exhibit 4 contains 1988 (or the most recently available) data on inpatient medical care beds per thousand inhabitants; inpatient days per capita; admissions to inpatient medical care institutions as a percentage of population; average length-of-stay per admission; and occupancy rates. These data update the information presented in the *Health Care Financing Review*, 1989 Annual Supplement (published by the OECD under the title *Health Care Systems in Transition*) and the analysis of bed availability and use presented in the OECD's *Financing and Delivering Health Care*.⁷

Beds per capita ranged from 2.1 per thousand population in Turkey to 15.6 in Japan, with an OECD average of 9.2. The United States, at 5.1 beds per thousand, had the fourth-lowest ratio, significantly below the ratios in the other six major industrialized countries (Canada, France, Germany, Italy, Japan, and the United Kingdom). While definitional imprecision may account for some of these differences, other studies, and

Exhibit 4
Availability And Use Of Inpatient Medical Care Services In Twenty-Four OECD Countries, 1988

	Inpatient beds per 1,000 inhabitants	Inpatient days per capita	Admissions as percent of total population	Average length-of-stay (days)	Inpatient occupancy rate
Australia	9.9	3.2 ^a	-	-	81.2% ^a
Austria	10.7	3.3	22.8%	12.9	82.8
Belgium	8.3	2.7	15.8	14.6	86.7
Canada ^b	6.9	2.0	14.5	13.2	82.7
Denmark	6.1	1.8	20.9	8.6	81.3
Finland	13.5	4.1	22.8	18.1	83.7
France	10.2	3.0	22.3	13.1	81.2
Germany	10.9	3.5	21.5	16.6	86.5
Greece	5.2	1.4	12.1	11.0	71.0
Iceland	14.8	5.0	27.5	18.2	93.0
Ireland	6.4	2.8	15.2	8.1	80.1 ^c
Italy	7.5	1.9	16.6	11.7	70.2
Japan	15.6	4.1	7.8	52.1	84.1
Luxembourg	12.5	3.7	19.0 ^d	19.8 ^d	81.0
Netherlands	11.7	3.8	10.9	34.8	89.0
New Zealand	9.0	2.1	13.0 ^b	12.9 ^d	-
Norway	15.3	5.1	16.7	10.1	89.1
Portugal	4.7	1.1	9.6	12.2	70.2
Spain	4.4 ^b	1.2	9.4 ^b	13.1 ^b	76.4
Sweden	13.3	4.0	20.0	19.1	85.1
Switzerland	9.9	3.0	16.6	25.3	83.9
Turkey	2.1	0.4	5.0	6.9	55.5
United Kingdom	6.5	2.0	15.9	15.0 ^b	80.6 ^d
United States	5.1	1.3	13.8	9.3	69.2
OECD average	9.2	2.8	16.1	16.4	80.2

Sources: OECD *Health Systems: Facts and Trends* (Paris: OECD, forthcoming); and OECD Health Data, 1991.

^a 1985.

^b 1987.

^c 1980.

^d 1986.

the more refined acute care hospital information presented below, paint a similar picture of these relative bed-to-population configurations.⁸

Use of inpatient days per person per year ranged from 0.4 in Turkey to 5.1 in Norway, with an OECD average of 2.8. The United States, at 1.3 days, was again the fourth-lowest country. There is a very high correlation of 0.96 between bed availability and use, lending support to the hypothesis that the greater the bed availability, the more likely beds will be used. (Ideally, a fully specified model of the demand and supply of hospital services should be developed, to measure properly all interrelationships among hospital use and availability measures.)

The use of inpatient services can be further broken down in terms of

admission rates and average lengths-of-stay.⁹ The number of admissions relative to the total population ranged from 5.0 percent in Turkey, a country with a relatively young population and a very limited number of beds, to 27.5 percent in Iceland, with an OECD average of 16.1 percent. The United States had the eighth-lowest admission rate at 13.8 percent. There is a relatively weak correlation of 0.50 between beds per thousand population and admission rates, indicating that a greater relative supply of beds does not necessarily lead to higher admission rates. However, occupancy rates, which are analyzed below, may be a more important determinant of admissions.

Average lengths-of-stay ranged from 6.9 days in Turkey to 52.1 days in Japan, with an OECD average of 16.4 days (14.8 excluding Japan). The United States, with an average length-of-stay of 9.3 days, had the fourth-lowest average. Clearly, both definitional and medical practice differences (such as use of hospitals for chronic care for the elderly) seriously affect these data. However, as shown below and in other studies analyzing average lengths-of-stay by disease category, these relative rankings generally hold, with U.S. figures the lowest of all major industrialized countries.¹⁰ Average lengths-of-stay correlate weakly with bed availability, with a correlation of 0.59 (0.53 if Japan is excluded).

The extent to which available beds are used determines the occupancy rate. The occupancy rate ranged from 55.5 percent in Turkey to 93 percent in Iceland, with an OECD average of 80.2. The U.S. occupancy rate of 69.2 was the second-lowest after Turkey. There is only a weak correlation of 0.41 between occupancy rates and average lengths-of-stay.¹¹ The somewhat higher correlation of 0.60 between occupancy rates and admission rates may suggest that occupancy rates are more sensitive to admissions than to lengths-of-stay.

These results, which may appear counterintuitive given the presumed greater ease in increasing lengths-of-stay as opposed to generating admissions, underlie the need for a well-developed behavioral model that specifically incorporates the effects of payment incentives on availability and use of services. For example, the diagnosis-related groups (DRGs) used in the U.S. Medicare program provide incentives for shorter stays and increased admissions, while the hospital global budget payment formulas used in a number of countries simply provide incentives to keep beds filled, which may be accomplished more easily by increasing lengths-of-stay than by generating admissions. Once again, the need for detailed comparative information on the institutional details of different countries' payment practices is apparent.

Acute care hospital services. Exhibit 5 contains a new data series developed by the OECD Secretariat on the availability, use, and expen-

Exhibit 5
Availability, Use, And Expenditures For Acute Care Hospitals In Seventeen OECD Countries, 1988

	Beds per 1,000 population	Bed days per capita	Admission rate ^a	Average length-of-stay (days)	Occupancy rate	Expenditure per capita ^b	Expenditure per day ^b	Expenditure per admission ^b
Australia	5.4	1.3	21.2% ^c	6.1 ^c	67.7% ^c	\$418	\$322	\$1,972
Austria	6.4	2.4	20.6	11.4	81.3	-	-	-
Belgium	5.5	1.5	16.5	9.6 ^d	76.1 ^d	-	-	-
Canada ^e	4.5	1.3	13.3	8.9	80.3	592	455	4,444
Denmark	4.8	1.4	20.2	6.9	80.5	388	277	1,921
Finland	4.5	1.2	16.7	7.3	73.8	198	165	1,186
France	5.4	1.5	20.1	7.3	76.4	515	343	2,562
Germany	7.4	2.3	18.7	12.7	85.5	-	-	-
Iceland	9.8	3.2	25.3	12.8	90.7	-	-	-
Ireland	3.9	1.2	13.9	7.3	82.2	-	-	-
Netherlands	4.5	1.2	10.4	11.9	74.0	335	279	3,221
Norway	4.5	1.3	14.9	8.5	77.4	440	338	2,953
Spain ^c	3.4	0.9	9.2	10.0	73.4	223	242	2,372
Sweden	4.1	1.2	16.8	7.1 ^c	78.4	-	-	-
Switzerland	6.6	1.3	13.8	13.7	80.7	398	210	2,884
United Kingdom ^c	2.8	0.9	12.9	7.8	76.4	-	-	-
United States	3.8	0.9	12.8	7.2	65.5	715	779	5,609
Average	5.1	1.5	16.3	9.2	77.7	422	341	2,912

Sources: OECD Health Systems: Facts and Trends (Paris: OECD, forthcoming); and OECD Health Data, 1991.

^a Percent of total population.

^b In U.S. dollars, gross domestic product purchasing power parities.

^c 1987.

^d 1983.

^e 1986.

ditures for acute care hospital services in 1988 (or the most recent available year). While the data (especially the expenditure data) are not complete for all countries, this information provides a significant step forward in analyzing the performance of health systems. The definition of acute care hospitals used here is an institution or ward in which average length-of-stay typically does not exceed thirty days.

The basic ranking of the United States for acute hospital care is similar to its ranking for all inpatient medical care. For example, of the seventeen reported countries for acute care beds per thousand population, the United States had the third-lowest ratio after the United Kingdom and Spain, with a U.S. ratio of 3.8 beds per thousand population, compared with a seventeen-country OECD average of 5.1 beds. With respect to acute care hospital days per capita, the United States at 0.9 had the lowest number of bed days per capita, the same as Spain and the United Kingdom, but well below the seventeen-country OECD average of 1.5 bed days. For the acute care admission rate, the United States had the third-lowest after Spain and the Netherlands, 12.8 percent, compared with a seventeen-country OECD average of 16.3 percent. The United States had the fourth-lowest average length-of-stay after Australia, Den-

mark, and Sweden, 7.2 days, compared with a seventeen-country OECD average of 9.2 days. The United States had the lowest occupancy rate, 65.5 percent, compared with a seventeen-country average of 77.7 percent. Overall, as in the case of all inpatient medical care beds, the United States tended to have fewer acute care beds per capita and lower use rates (days per capita, admissions, average length-of-stay, and occupancy rate).

Expenditure data for acute hospital care are available for ten countries (Exhibit 5). Unfortunately, these data are not strictly comparable because they include the salaries of hospital-based physicians for those countries in which these physicians are salaried hospital employees. Thus, the acute care hospital expenditure information runs along a spectrum of inclusiveness from some countries (such as Spain and the Scandinavian countries) in which virtually all hospital-based physician spending is included, to others in which only some is included (such as France) to countries in which virtually no physician spending is included since almost all inpatient physician services are paid for separately on a fee-for-service basis (such as the United States and Canada). Thus, these data must be interpreted with caution. Moreover, while availability, use, and outcome measures change little from year to year, relatively high health care inflation can cause significant year-to-year spending increases. Thus, comparisons based on expenditure averages from different years must be treated more cautiously than similar figures for these other measures.

In every category, U.S. spending is by far the highest, a finding emphasized by the omission of inpatient physician spending in the U.S. data. U.S. expenditures per person of \$715 exceeded the ten-country average of \$422 by 69 percent and were 11 percent higher than in Canada, the second-highest country.¹² U.S. expenditures per day of \$779 exceeded the \$341 OECD average by 128 percent and exceeded Canada, the second-highest country, by 55 percent.¹³ U.S. expenditures per admission of \$5,609 exceeded the \$2,912 OECD average by 93 percent and were 14 percent higher than in Canada, the next-highest country.¹⁴

Interpreting the expenditure data with the information on use of services paints a picture of relatively low use of services and high unit costs in the United States. Perhaps this is due to far more intensive treatment during relatively short stays, higher labor and capital costs, greater inefficiency, better amenities, or higher quality-of-care standards. Neither comprehensive and systematic data nor a full-blown methodology to separate these effects exists. Moreover, even if these factors could be fully measured, to draw meaningful conclusions one would still need to know the effect of all of this on health outcomes.

Physician services. Exhibit 6 provides information on physician availability, physician contacts per person, and expenditures per capita and

Exhibit 6
Availability, Use, And Expenditures For Physician Services In Twenty-Four OECD Countries, 1988

	Physicians per 1,000 population	Physician contacts per capita	Physician expenditures per capita ^a	Physician expenditures per physician ^a
Australia	2.0 ^b	8.4 ^c	\$181	\$ 81,430 ^b
Austria	2.0	5.8	-	-
Belgium	3.3	7.5	-	-
Canada ^c	2.2	6.6	241	112,035
Denmark	2.7	5.2 ^d	-	25,895 ^e
Finland	1.9	3.7	-	-
France	2.6	7.1	147	57,270
Germany	2.9	11.5	193	67,067
Greece	3.2	5.3 ^f	-	-
Iceland	2.7	4.9 ^g	-	-
Ireland	1.5	6.6	-	26,057 ^e
Italy	1.3 ^h	11.0	-	72,926 ^e
Japan ^c	1.6	12.9	306 ^b	183,761 ^b
Luxembourg	1.9	-	-	90,992 ^e
Netherlands	2.4	5.1	113	46,702
New Zealand	1.9	3.8 ^g	124	67,009
Norway	2.5 ^c	5.7 ^d	-	-
Portugal	2.7	2.7	-	-
Spain	3.6	4.0 ^b	-	-
Sweden	2.9	2.8	-	-
Switzerland	2.9	6.0 ^c	247	85,640
Turkey	0.8	2.0 ^d	-	-
United Kingdom	1.4	4.5 ^b	-	34,823 ^e
United States	2.3	5.3	414	183,281
Average	2.3	6.0	219	98,244 ⁱ

Sources: OECD Health Systems: Facts and Trends (Paris: OECD, forthcoming); and OECD Health Data, 1991.

^a In U.S. dollars, gross domestic product purchasing power parities.

^b 1986.

^c 1987.

^d 1985.

^e Public expenditures only.

^f 1982.

^g 1981.

^h Hospital-based physicians only.

ⁱ Average does not include public-expenditure-only countries.

per physician for 1988 (or the most recently available year). The number of physicians per thousand population ranged from 0.8 in Turkey to 3.6 in Spain, with an OECD average of 2.3. The U.S. ratio is the same as the average, roughly equivalent to Canada, well above Japan and the United Kingdom, but below France and Germany. Unfortunately, these data tell only part of the story. Clearly, the mix between primary care and specialist physicians is of critical importance. Unfortunately, these data are not readily available. Other studies comparing more limited numbers of

countries show more specialists than general practitioners (GPs) and other primary care physicians in the United States compared with other countries (such as Canada and the United Kingdom).

There is also significant variability in physician contacts per person per year. Unfortunately, a consistent definition, such as the sum of all office-based consultations, hospital outpatient consultations, home visits by physicians, and other consultations, is far from universally implemented. Both the content and reported number of contacts are heavily influenced by payment rules. In some countries, telephone contacts and prescription renewals without face-to-face contact are recorded as contacts, while in others they are not. For those countries in which salaried hospital-based physicians are reimbursed as part of the hospital service, inpatient contacts are frequently not separately reported from the hospital episode. Thus, these data must be interpreted with caution.¹⁵

Physician contact rates varied from 2.0 per capita in Turkey to 12.9 in Japan, with an OECD average of 6.0. The correlation between consultations and physician availability is -0.10 (not statistically significant), indicating no relationship between physician availability and contacts per person.¹⁶ However, a well-specified demand and supply model incorporating physician payment methods, cost-sharing provisions, and so on is clearly needed to appropriately study the relationship between availability and use. Unfortunately, there is still insufficient comparable information to provide an empirical basis for a solid analysis.

Exhibit 6 also contains new OECD information on physician expenditures per person and per physician for Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Switzerland, and the United States for 1988 (or the most recent available year). These data are not strictly comparable because they exclude expenditures for physicians who are salaried employees of hospitals and other facilities. So, for example, French data exclude salaries of physicians practicing in public hospitals, while German data exclude most hospital-based physicians.

Physician expenditures per capita ranged from \$113 in the Netherlands to \$414 in the United States, with a nine-country average of \$219. Physician expenditures per physician ranged from \$46,702 in the Netherlands to \$183,761 in Japan, with a nine-country average of \$98,244. The United States had the second-highest spending per physician at \$183,281. Compared with Canada, a country with a similar physician-to-population ratio and similar extensive reliance on fee-for-service payment, the United States spent 53 percent more per person and 48 percent more per physician.¹⁷ The high Japanese figures may reflect substantial reliance on fee-for-service reimbursement and substantial incomes from physician-owned clinics, coupled with a low physician-to-

population ratio and high consultation rates. It is difficult to make inferences regarding the other countries, given the data limitations and/or lack of detailed information on the extent to which expenditures for salaried physicians are excluded.

Pharmaceuticals. Exhibit 7 contains information on the number of pharmacists per thousand population, outpatient pharmaceutical expenditures as a percentage of total health expenditures, and pharmaceutical expenditures per person. The expenditure data include spending for over-the-counter drugs but exclude pharmaceutical expenditures for inpatients. Data are for 1988 (or the most recent year available).

The number of pharmacists per thousand population ranged from 0.15

Exhibit 7
Availability, Use, And Expenditures For Pharmaceutical Services In Twenty-Three OECD Countries, 1988

	Pharmacists per 1,000 population	Pharmaceuticals as percent of total health expenditures	Pharmaceutical expenditures per capita ^a	Pharmaceutical expenditures per capita ^b
Australia	0.66 ^c	8.3%	\$187	\$ 92
Austria	0.25	11.6	152	121
Belgium	1.18	17.4	304	161
Canada	0.80	11.6 ^d	187 ^d	175 ^d
Denmark ^d	0.29	9.3	140	78
Finland	0.86	9.5	158	95
France	0.91	16.7	492	196
Germany	0.56	20.7	321	258
Greece	0.69	26.3	187	90
Iceland	0.74 ^d	12.9	-	174
Ireland ^d	0.31	11.2	96	68
Italy	-	18.2	349	179
Japan	0.69	18.4	332	179
Luxembourg	0.77	15.5	325	178
Netherlands	0.15	9.6	134	103
New Zealand	0.67	14.3	242	115
Norway	0.45	5.3	106	65
Portugal	1.08	18.2 ^c	88 ^c	60 ^c
Spain	0.87	18.8 ^d	204 ^d	106 ^d
Sweden	0.51 ^c	6.7	189	89
Switzerland	-	12.3	-	159
United Kingdom	-	11.3	201	88
United States	0.66 ^c	8.3	182	182
Average	0.65	13.6	218	129

Sources: OECD Health Systems: Facts and Trends (Paris: OECD, forthcoming); and OECD Health Data, 1991.

^a In U.S. dollars, pharmaceutical purchasing power parities.

^b In U.S. dollars, gross domestic product purchasing power parities.

^c 1986.

^d 1987.

^e 1985.

in the Netherlands to 1.18 in Belgium, with a twenty-country OECD average of 0.65. The United States, with an average of 0.66, was quite close to the average. Outpatient pharmaceutical spending ranged from 5.3 percent of total health spending in Norway to 26.3 percent in Greece, with a twenty-three-country (excluding Turkey) OECD average of 13.6 percent. The United States and Australia, at 8.3 percent, had the third-lowest pharmaceutical expenditure percentage and were significantly below the OECD average. The United States also had a percentage well below the comparable figures in all six of the major OECD countries. Pharmaceutical spending ranged from \$88 per person in Portugal to \$492 in France, with a twenty-one-country average (excluding Iceland, Switzerland, and Turkey) of \$218.¹⁸ The United States, at \$182 per person, was well below the OECD average and below all six of the major OECD countries. Studies suggest that the U.S. situation is characterized by relatively low utilization per person, and high prices per unit of service.¹⁹

Health Outcome Measures

Socioeconomic, cultural, geographic, social program, health system, and other factors determine the health status of populations of different countries.²⁰ Data and methodological constraints preclude evaluation of the health outcome effects of specific policy interventions and/or health systems' features on health outcomes. However, it is useful to review life expectancy and infant mortality, as well as general population measures, to point out differences in the underlying demographics and gross disparities in various health status measures in different countries (Exhibit 8).

Population characteristics. Percentage of population age sixty-five and over varied from 4 percent in Turkey to 17.8 in Sweden, with an OECD average of 13 percent. The United States (12.3 percent) had the eighth-lowest ratio. Of the major OECD countries, only Canada and Japan had lower percentages. Since health care costs increase with age, one would expect countries with relatively younger populations to have lower expenditures, other things being equal.

Another measure of population dependency is the total dependency ratio (the population less than age twenty and age sixty-five and over relative to the "productive" population ages twenty to sixty-four). This ratio provides a measure of the ability of the productive working population to support the young and elderly populations. The lower the ratio, the more individuals in the productive age ranges to care for the dependent young and elderly. The dependency ratio ranged from 57.8 percent in Luxembourg to 105.8 percent in Turkey, with an OECD average of 71.1 percent. The U.S. ratio of 70.3 is about average and falls in the

Exhibit 8
Population And Health Outcome Measures In Twenty-Four OECD Countries, 1988

	Infant mortality, live births per 1,000	Perinatal mortality, deaths per 1,000*	Life expectancy at birth, male (years)	Life expectancy at birth, female (years)	Life expectancy at age 80, male (years)	Life expectancy at age 80, female (years)	Percent of population over age 64	Dependency ratio ^b
Australia	8.7	10.7	73.1	79.5	6.7	8.4	10.9%	71.6
Austria	8.1	7.4	72.0	78.6	6.3	7.4	14.9	66.0
Belgium	9.4	10.4 ^c	71.4 ^d	78.2 ^d	5.7 ^e	7.1 ^e	14.5	65.7
Canada	7.2	7.6	73.0 ^c	79.7 ^c	6.9 ^e	8.9 ^e	11.1	65.2
Denmark	7.5	8.7	71.8	77.7	6.4	8.2	15.4	67.0
Finland	6.1	6.5	70.7	78.7	6.1	7.5	13.1	63.0
France	7.7	9.2	72.3	80.6	6.8	8.6	13.6	71.7
Germany	7.6	6.5	71.8	78.4	6.1 ^d	7.6 ^d	15.4	57.9
Greece	11.0	12.9	74.1 ^d	78.9 ^d	6.7 ^e	7.6 ^e	13.6	68.6
Iceland	6.2	7.5	74.6	79.7	7.2	8.9	10.5	78.4
Ireland	8.6	10.4 ^d	71.0	76.7	5.5 ^e	6.4 ^e	11.1	95.2
Italy	9.3	12.3	72.7 ^d	79.4 ^d	6.2 ^d	7.7 ^d	13.6 ^d	65.8 ^d
Japan	4.8	6.2	75.5	81.3	6.9	8.4	11.2	63.7
Luxembourg	9.4	7.1	70.6 ^c	77.9 ^c	5.3 ^e	6.8 ^e	13.3	57.8
Netherlands	6.8	9.2	73.3	79.9	6.7	8.6	12.5	62.9
New Zealand	10.8	8.5	71.0 ^d	77.3 ^d	6.2 ^e	7.9 ^e	10.7	76.4
Norway	8.3	7.9	73.1	79.6	6.5	8.1	16.1	75.7
Portugal	13.0	15.3	70.7	77.6	5.8 ^d	6.9 ^d	12.9	76.3 ^c
Spain	8.1	10.6 ^c	73.2 ^d	79.8 ^d	6.7 ^e	7.7 ^e	13.1	74.2
Sweden	5.8	6.8	74.2	80.0	6.3	8.1	17.8	73.1
Switzerland	6.8	7.6 ^d	73.9	80.7	6.9	8.6	14.8	61.6
Turkey	65.0	-	63.2 ^e	68.1 ^e	5.1 ^e	5.6 ^e	4.0	105.8
United Kingdom	9.0	9.1	72.4	78.1	6.4	8.1	15.6	72.0
United States	10.0	9.7	71.5	78.3	6.9	8.7	12.3	70.3
Average	10.6	9.0	72.1	78.5	6.3	7.8	13.0	71.1

Sources: OECD Health Systems: Facts and Trends (Paris: OECD, forthcoming); and OECD Health Data, 1991.

* Includes live births and late fetal deaths.

^b Dependency ratio defined as number of population ages 0-19 and 65 and older, divided by number of population ages 20-64.

^c 1986.

^d 1987.

^e 1980.

^f 1985.

^g Average for 1985-1989.

middle of the range for the major industrialized countries. Children under one year of age, the elderly, and the disabled account for the highest per capita health expenditures. Unfortunately, recent spending ratios for these groups for a large number of countries are not readily available.²¹

Infant mortality. Infant mortality (deaths in the first year per thousand live births) is widely used as a measure of health outcomes. Others have argued that perinatal mortality—the number of late fetal deaths (after twenty-eight weeks of gestation) plus infant deaths within seven days of birth divided by the number of live births plus late fetal deaths—is a superior measure of health system performance, since it is affected more directly by specific health interventions well into the pregnancy.

The 1988 OECD infant mortality rates ranged from 4.8 deaths per thousand live births in Japan to 65.0 in Turkey, with an OECD average

of 10.6 (8.2 excluding Turkey). The United States, with an infant mortality rate of 10.0, ranked twentieth among the OECD countries. For perinatal mortality, the range went from 6.2 deaths per thousand births and late fetal deaths in Japan to 15.3 in Portugal, with a twenty-three-country (excluding Turkey) OECD average of 9.0. The United States, with a perinatal mortality rate of 9.7, ranked sixteenth.

There is only a very weak relationship between infant deaths and health spending, irrespective of whether infant mortality or perinatal mortality is used. The correlations of infant mortality to per capita health spending and the health-to-GDP ratio are -0.49 and -0.47, respectively, while the comparable figures for perinatal mortality and health spending are -0.53 and -0.37.²² Perhaps, as Bengt Jönsson has pointed out, the rather poor U.S. performance on both infant death measures, given its high overall spending level, results from a lack of systematic focus on prenatal care, which appears to be less of a problem in countries with comprehensive national systems.²³

Life expectancy. Life expectancy at various ages is also used as a measure of health system outcomes. Life expectancy at birth for females ranged from 68.1 years in Turkey to 81.3 in Japan, with an OECD average of 78.5 (79.0 excluding Turkey). The United States, with a female life expectancy of 78.3 years, ranked sixteenth; its female life expectancy was below those in all six major countries except the United Kingdom. Male life expectancy at birth ranged from 63.2 years in Turkey to 75.5 in Japan, with an OECD average of 72.1 (72.5 excluding Turkey). U.S. male life expectancy was 71.5 years; the United States ranked seventeenth with a male life expectancy below those in all six major OECD countries.

Some have argued that life expectancy in the older age ranges may provide a better indication of the availability and use of high-technology health interventions and hence may be more influenced by health spending than is life expectancy at birth. Life expectancy at age eighty for females ranged from 5.6 years in Turkey to 8.9 years in Iceland and Canada, with an OECD average of 7.8 years (7.9 excluding Turkey). U.S. female life expectancy at age eighty was 8.7 years and was the second-highest after Iceland and Canada. Male life expectancy at age eighty ranged from 5.1 years in Turkey to 7.2 years in Iceland, with an OECD average of 6.3 years (6.4 excluding Turkey). The United States (6.9 years) ranked second along with Canada, Japan, and Switzerland.

The correlations of per capita health spending and health-to-GDP ratios with life expectancy at birth are 0.42 and 0.41, respectively, for males, and 0.52 and 0.51 for females. For life expectancy at age eighty, the comparable figures are 0.57 and 0.35 (not statistically significant) for males, and 0.73 and 0.49 for females. The correlations between life

expectancy and health-to-GDP ratios are all weak and suggest little or no relationship between life expectancy and health-to-GDP ratios. However, the correlations between life expectancy and per capita health spending are somewhat stronger, and the correlations for life expectancy at age eighty are significantly higher for both sexes than the respective correlations at birth, lending support to the hypothesis that higher health spending results in greater availability of medical interventions, which, in the higher age ranges, postpones death.²⁴

These kinds of analyses are extremely simplistic, since they do not account for the plethora of other factors affecting life expectancy. Moreover, life expectancy is far from an ideal measure of quality of life or health outcome. However, they may provide some support for relatively favorable health outcomes in the higher age ranges in the United States resulting from higher U.S. levels of spending. Clearly, a great deal of more detailed work needs to be done in this area.

In sum, the rhetoric in the popular press, trade press, professional journals, and governmental publications attests to the strong interest in learning from other countries. We hope that with continued effort, our knowledge base will begin to match the rhetoric.

The views expressed in this paper are those of the authors and do not necessarily represent those of their respective organizations.

NOTES

1. G.J. Schieber and J.P. Poullier, "International Health Spending: Issues and Trends," *Health Affairs* (Spring 1991): 106-116.
2. The revised historic Australian health-to-GDP ratios are 5.7 percent for 1970, 7.5 percent for 1975, 7.4 percent for 1980, and 7.8 percent for 1985. In per capita health spending in U.S. dollars, the historic figures are \$205 in 1970, \$433 in 1975, \$595 in 1980, and \$952 in 1985.
3. G.J. Schieber and J.P. Poullier, "International Health Care Expenditure Trends: 1987," *Health Affairs* (Fall 1989): 169-177.
4. *Ibid.*
5. See *Comparative Health Systems*, ed. M. Raffel (University Park and London: The Pennsylvania State University Press, 1984); and Organization for Economic Cooperation and Development, *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries* (Paris: OECD, forthcoming).
6. See OECD, *Measuring Health Care* (Paris: OECD, 1985); J.P. Poullier, "Health Data File: Overview and Methodology," *Health Care Financing Review* (1989 Annual Supplement): 111-118; and OECD, *OECD Health Systems: Facts and Trends* (Paris: OECD, forthcoming).
7. Health Care Financing Administration, *Health Care Financing Review* (1989 Annual Supplement); and OECD, *Financing and Delivering Health Care* (Paris: OECD, 1987). The OECD edition of the HCFA publication is OECD, *Health Care Systems in Transition* (Paris: OECD, 1990).
8. *Ibid.*

Speech writers ✓

fax to McConnell

Environment ✓

File

Document Originally
Attached to
Following Page

THE WALL STREET JOURNAL.

MARKETPLACE



ENVIRONMENT

BY BARBARA ROSEWICZ

Desktop PCs Will Save Energy by Snoozing

ENERGY-EFFICIENT computers will reach market within a year, and the federal government — known more often for its bureaucracy than for inspiration — deserves the credit.

Nine computer makers, including Apple Computer, Hewlett-Packard and International Business Machines, plan to produce desktop personal computers that will save energy by going into a "sleep" mode when not in use. The feature, spurred by a suggestion from the Environmental Protection Agency, is expected to cut computers' energy use in half. PCs with the feature will carry an EPA Energy Star pollution-preventer logo, and the agency says it won't make computers more costly.

By the year 2000, the computers could save \$1 billion of electricity a year. Building managers such as Mobil's Fred Schoeneborn also like the idea because the PCs will emit less heat, requiring less air conditioning, and will cut down on power demand in older buildings whose electrical systems weren't designed to power a computer on every desk.

The EPA says PCs on average are actively used only 20% of the time. A desktop model uses electricity equivalent to a 150-watt light bulb. A sleep mode — now found only in some battery-powered laptop computers — could reduce that to perhaps 30 watts. A touch of any key would bring the computer back to full power.

Efficient computers caught the eye of the EPA's global-change division mainly as a way to curb the threat of global warming, which is blamed in part on the burning of fuel to make electricity. The Bush administration is counting on a series of such "green" product developments to achieve about half of the carbon-dioxide reductions which it agreed to pursue at the Earth Summit.

The EPA already has signed up 600 institutions to voluntarily install energy-efficiency lighting. It plans to seek similar voluntary agreements to promote variable-speed fans for building heating and cooling systems, energy-efficient household appliances and rebates for energy-saving industrial motors.



UNITED STATES ENVIRONMENTAL PROTECTION AGENCY
WASHINGTON, D.C. 20460

OFFICE OF
AIR AND RADIATION

Speech Insert on Green Lights

EPA is following through on the President's Rio commitments by implementing a series of programs which suggests not only that reducing greenhouse gases is achievable at low cost -- but that it is actually profitable! EPA's voluntary **green programs** use market forces to improve energy efficiency throughout the U.S. economy. The programs are providing win-win results for business profitability and the environment.

EPA's flagship is **green lights** -- a voluntary government/industry partnership in which companies install energy efficient lighting throughout their facilities. Companies are saving 40-70% of the electricity used in lighting (which is approximately one-third of their electric bill) and millions of dollars annually in utility bills -- all while improving the quality of the lighting in offices and factories across the U.S. and reducing emissions associated with generating electricity. Over 600 companies and state/local governments are participating in the program so far -- this is equivalent to all of the office space in New York, Houston, Chicago, Los Angeles, Dallas, San Francisco, and Washington DC **combined**.

EPA has a number of other voluntary green programs underway -- programs that save energy, save money, and help the environment. Efforts addressing computers (currently over 5% of commercial electricity consumption) and refrigerators (the largest energy user in the home after heating and cooling) have been announced and are running. These efforts provide excellent models for the many other areas in which great potential savings exist. Examples include embarking on a building-wide efficiency program late this fall and addressing residential heating and cooling early next year.





EMBASSY OF THE
UNITED STATES OF AMERICA

Port Louis, Mauritius

August 11, 1992

Mr. Richard W. Porter
Counselor to the Vice President
Old Executive Office Building
Washington, D.C.

Dear Mr. Porter,

Thanks so much for passing me copies of the Vice President's recent speeches. They are interesting to have and to share with my staff.

May I ask that the computer entry for my name be corrected from Mr. Korth, to Mrs. or to Ambassador Korth.

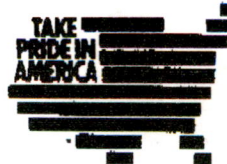
Wishing you all the best.

Cordially,

Penne Percy Korth
Ambassador



United States Department of the Interior

OFFICE OF THE SECRETARY
Washington, D.C. 20240

TRANSMISSION NOTICE

This message is electronically transmitted on a Canon
FAX-L770 automatic machine.

Transmission Number: 202-208-4561

Verification Number: 202-208-4203

TO:

Name

Richard Porter

Agency/Phone #

(202) 456-2223

From:

Tom Weiner

Office of the Secretary
1849 C Street, N. W.
Washington, D. C. 20240

No. of pages to follow:

1

Date:

8/14/92

Time:

9:22am

TITLE: Barred Owl x Spotted Owl Hybrids

ISSUE: The northern spotted owl was listed as a threatened species on June 6, 1990.

Statements have been made that the spotted owl will become extinct due to competition and hybridization with barred owls, recovery is not possible, and therefore should not be attempted.

STATUS: Barred owls and spotted owls were geographically isolated at one time.

Barred owls are expanding their range into areas occupied by northern spotted owls and in some cases displacing them.

Since 1989, 7 cases of hybridization between barred and spotted owls have been confirmed.

This barred owl x spotted owl hybridization is relatively uncommon as suggested by only 7 documented cases out of thousands of pairs of spotted owls observed.

About 10% of non-marine bird species in North America have been known to hybridize. Hybridization tends to be an uncommon event and has little short-term impact on the species--they still persist as distinct species.

The level of hybridization observed between spotted owls and barred owls does not exceed that which would be expected according to scientists who have been studying the species.

The draft recovery plan for the northern spotted owl does not identify hybridization as a significant threat to the species.

DEPARTMENTAL POSITION: There is no departmental position at this time.

Spotted owl



United States Department of the Interior

OFFICE OF THE SECRETARY
Washington, D.C. 20240

TRANSMISSION NOTICE

This message is electronically transmitted on a Canon
FAX-L770 automatic machine.

Transmission Number: 202-208-4561

Verification Number: 202-208-4203

TO:

Name

Richard Porter

Agency/Phone #

From:

Tom WernerOffice of the Secretary
1849 C Street, N. W.
Washington, D. C. 20240No. of pages to follow: 1Date: Time:

Species Extinction

I talked with Professor E. O. Wilson of Harvard; he said he had used the quote, "97% of all identified species are extinct," but that it was originally made by Professor David M. Raup of the University of Chicago. Wilson said care must be taken to note that the quote refers to all of the species known over the past 2 billion years. He said further that to use this as an argument that it is therefore inconsequential to attempt to avert further extinction would be "fallacious."

Wilson noted that most of the people who have ever lived on Earth are already dead, and said it would make as much sense for people to use this as justification for the continuation of genocide.

I found Professor Raup at the University of Chicago. He said the number he actually used was "99.9% of all species that have ever lived" are probably now extinct. But he said to use that as an argument for the abandonment of further efforts to avert extinction of species would not be relevant. "Geologic extinction for this kind of argument is not relevant," was his precise quote. He also agreed with Professor Wilson's analogy about genocide, and said it was a particularly good one.

Professor Raup's citation of this number most recently is mentioned in the foreward of his book, "Extinction; Bad Genes or Bad Luck?", published by Norton and still in print.

Doctors Group Backs Health Costs Cap

American College of Physicians Embraces Clinton-Like Proposal

By Spencer Rich
Washington Post Staff Writer

The American College of Physicians broke with most other doctors organizations yesterday and called for a national cap on health care spending, enforced by "limits on doctor and hospital fees."

"We announce our support for a national health care budget and reasonable limits on fees," to be set in negotiations with doctor and hospital groups, said Willis C. Maddrey, president of the group whose mem-

bership of 77,000 doctors of internal medicine makes it the nation's largest society of medical specialists.

The proposal comes in the middle of a presidential election campaign in which rising health care costs are a subject of major debate.

The physicians group is the second major doctors group to support some sort of limit on physicians fees—the 74,000-member American Academy of Family Physicians took a similar stance several months ago. All others—including

the American Medical Association, the largest with about 300,000 members—strongly oppose direct government cost controls, as does President Bush. The physicians' proposal resembles that of Democratic nominee Bill Clinton.

Bush favors marketplace competition between large medical groups to determine which can provide insurance and care at the lowest cost; changes in private insurance rules to cut costs and guarantee that everyone can buy insurance, and re-

See DOCTORS, A9, Col. 1

Physicians Group Backs Cap On Hospital, Doctors Fees

DOCTORS, From A1

vision of medical malpractice liability laws to hold down costs.

Clinton's proposal for containing health costs has a similar national cost cap (or "global budget") as its central feature. But ACP officials said they have been working on their plan for five years and did not announce it yesterday as a way of taking a position in the presidential campaign.

Nonetheless, a Clinton aide yesterday called it "absolutely a breakthrough" and said it is "a clear example of physicians showing leadership and moving to the forefront of the reform effort."

"The most significant feature of the plan being presented here is who is presenting it," said the American Association of Retired Persons' John Rother, who endorsed the physicians' plan.

Maddrey said his group, which had "long resisted government involvement" in direct spending controls and setting of fees, recognizes "times have changed" because health costs are rising so fast.

But Ray Scalettar, chairman of the AMA's board of trustees, called the

idea a "naive approach. What it fails to recognize is that physicians and patients are interested in health care. The government is interested in cost." He said it would lead to "rationing of care, a ratcheting down on procedures and initiatives."

Gail Wilensky, a Bush health aide, said the administration opposes the ACP approach. She said it favors realigning the incentives within the medical system to hold down costs and "provide the financial wherewithal for people who are too low-income to find their own health care." But she said it does not favor having the government make all decisions and impose caps.

Besides negotiated cost caps, the ACP plan would mandate that all employers either "offer their own health coverage" to their workers or "pay a tax to enroll their workers in publicly sponsored insurance." The amount of the tax would be decided later.

Terry Hill, of the National Federation of Independent Business, which represents mostly small firms, said, "We will not support anything that has an employer mandate in it." He said his group is skeptical that cost caps would save much money.

Health Care Policy

NEW YORK TIMES 10 SEPTEMBER 1992

Administration Accuses Democrats of Blocking Bush's Health Plan

By ROBERT PEAR

Special to The New York Times

WASHINGTON, Sept. 9 — The Bush Administration complained today that House Democrats had blocked action on President Bush's proposal to guarantee health insurance coverage for virtually all Americans, even as Administration officials accused Gov. Bill Clinton of equivocating on health-care policy.

Not until February of this year did the President offer a detailed plan to help the 35 million Americans who lack health insurance. But he and his Administration are evidently hoping to make up for the delay by putting Democrats, especially Mr. Clinton, the party's Presidential nominee, on the defensive.

At a news conference on the grounds of the Capitol, Dr. Louis W. Sullivan, the Secretary of Health and Human Services, said today that he felt "increasing impatience and, indeed, anger at the inaction of the Congress in responding to the President's health-care reform proposal."

The Bush proposal would provide tax credits for poor people and tax deductions for middle-income people to help them buy private health insurance. By contrast, Mr. Clinton and many Democrats in Congress would require employers to buy private insurance for their employees or to participate in some type of public health program. Mr. Clinton has not said exactly how he would finance the public program, though many Democrats advocate new payroll taxes on employers who do not provide insurance for their workers.

"We'd like to know what the Clinton

plan is," Dr. Sullivan said today. "It seems to change with each news report." Mr. Clinton, unlike Mr. Bush, would set annual goals or limits for different types of health-care spending in an effort to control costs.

Republicans today gleefully cited the transcript of a meeting in July at which House Democrats discussed how they could use the health-care issue for maximum political gain in this election year. Dr. Sullivan said the transcript showed "the cynicism and the political gamesmanship" of Congressional Democrats, and he challenged them to allow a vote on Mr. Bush's plan.

Democrats accuse Bush of 8 years of inaction on health care.

At the meeting of the House Democratic caucus on July 24, lawmakers discussed the risks of doing nothing on health care this year and stressed that President Bush must not get credit for any action they might take. The transcript also exposes Democrats' divisions on this issue. The transcript was made by the Democratic caucus and a copy was provided by a Republican official who would not disclose how he obtained it.

Representative Richard A. Gephardt, the House Democratic leader, said at the caucus: "I do not want to

get out here on the floor discombobulated, disorganized, not know what in the world we are doing, and look foolish at the end of the day. I would rather do nothing than come out here and look dumb, dumber than we will look if we have nothing to say."

Mr. Gephardt said that "some are beginning, as Clinton's polls go up, to believe that we can get by with doing nothing" on health care this year. But Mr. Gephardt warned that President Bush would attack the Democrats if they did nothing.

Representative Dan Rostenkowski of Illinois, who is chairman of the Ways and Means Committee, said Democratic lawmakers could harm the Clinton-Gore campaign if they passed a bill with which the Democratic nominees were uncomfortable.

But Representative Henry A. Waxman of California, the chairman of the Energy and Commerce Subcommittee on Health, warned that Democratic legislators could damage themselves by doing nothing.

"Politically, we have raised the hopes of the American people that our party stands for doing something in the area of health-care reform," Mr. Waxman said. "People are looking to us to take a leadership role to solve the health-care problem. If we do nothing, they will read that as a failure of leadership."

House Democrats confirmed the accuracy of the transcript and said it was not surprising that they would discuss politics at a party caucus. "Good policy and good politics go hand in hand," Mr. Rostenkowski said.

George Stephanopoulos, a spokes-

Health insurance
becomes more
deeply mired in
party politics.

man for Governor Clinton, said it was Mr. Bush who had delayed on the health care issue.

"George Bush was sitting in the White House for eight years as Vice President and over three years as President before he even acknowledged that there was a health-care crisis in this country," Mr. Stephanopoulos said.

Mr. Bush has sent several health-care bills to Congress this year. They would, for example, set Federal standards for private health insurance, limit payments for damages in certain cases of medical malpractice and increase the use of electronic billing for health-care services.

But David E. Dreyer, a spokesman for Mr. Gephardt, said, "Dr. Sullivan is flat wrong when he says the Administration proposal is in any shape to be voted on now." In fact, Mr. Dreyer said, the President has not disclosed how he would pay for the most important element of his plan, the tax credits and deductions.

More national news
appears on page B8.

1 people in the divisions that we will have, and/or whether or
2 not when we come together, we will be able to come together
3 with a consensus and pass the bill.

4 I just think that the road is filled with good
5 intentions, but I would hate like heck at this point in time
6 to do something that would derail the upward swing that we
7 feel with Gore and Clinton doing such an outstanding job.

8 I underscore this very much. I am getting letters from
9 the Majority Leader and from Bill Gradison, observations
10 from the President of the United States about saying, Give
11 me a chance, give me my bill, at least let me have it
12 considered. That is what you will hear should we do
13 nothing. It will be that the Congress, they did not even
14 give me a chance at my bill.

15 So when the debate is over, and you have been convinced
16 or have not been convinced, I think you owe it to Dick
17 Gephardt, who has worked so hard, I think you owe it to him
18 to tell him that you will or will not support the measure,
19 because it would be terribly embarrassing for us to come to
20 the Floor, have the debate, and then not be able to pass a
21 piece of legislation.

22 Mr. Hoyer. Thank you.

23 Chairman Dingell?

24 * Mr. Dingell. Thank you, Mr. Chairman.

25 I would commend Dick Gephardt for having come forward

* SEE PAGE 16-17

1 with this initiative. And I want to support the comments
2 made by Dan Rostenkowski.

3 This is a proposal which we have not seen for the first
4 time. As my good friend Dick will remember, we had a
5 similar exercise back in the days of the Carter Presidency.
6 It is interesting to note it came a tremendous cropper. And
7 the result of that was that nobody much cared.

8 I would like to begin by saying, first, if we are going
9 to do it, we had better do it very carefully and prepare for
10 it very well, because the consequences of failure are indeed
11 very serious.

12 Second of all, there are two ways we can address this
13 problem. The first is to come forward with a package which
14 does the best we can, given the circumstances. We might get
15 a little political credit for it. We might not. That is
16 basically the package which you are seeing before us.

17 I really have some doubts that people are going to know
18 that we have really done anything or that we have really
19 addressed the issue. I feel there is only one way of
20 solving the problem. That is a single-payer national health
21 insurance program.

22 I think the components of that that count are these.
23 One, control of tort liability, malpractice reform. Two,
24 cost containment. Three, and an absolutely essential step
25 which has to be taken, that is financing by value-added

1 tax. This will get you business support.

2 Having said that, I support this, and we will do our
3 share to get it out of committee. But as Dan says, you are
4 going to have to support your leadership. You are going to
5 have to come forward with an honest statement of what you
6 are going to do on this, because if we come a cropper, it is
7 going to be a great big one, and I would urge you not to
8 commit to that folly in an election year.

9 I would tell you I very much want and I feel the only
10 sensible thing we can do if we are going to do this is, at
11 least start moving forward the basic issue of national
12 health insurance.

13 The average guy I talk to in my district says, I want
14 national health insurance. He doesn't greatly care about
15 cost containment. He doesn't care about the mechanism for
16 financing. And he doesn't care about malpractice reform.
17 Those aren't things he understands. They are absolutely
18 essential to it, but he wants one thing. He wants those
19 medical bills to be paid.

20 I think a component of what we are engaged in, and
21 remember, we are engaged in two things. The first thing we
22 are engaged in is the legislative exercise. The second
23 thing we are engaged in in a political year is a political
24 exercise to first of all work our own program forward, and
25 that is an honorable and proper thing to do, and second, to

1 screw the Republicans.

2 It is my honest belief --

3 Mr. Hoyer. Without objection, so ordered.

4 Mr. Dingell. I am not sure whether I got more time or
5 license to screw the Republicans.

6 In any event, if we are going to do this, I would urge
7 that we put on the Floor an opportunity for Members to have
8 a really meaningful vote on a national health insurance
9 program that is going to mean something to Joe Six-Pack out
10 there.

11 Now, if there are other ~~Members~~ who feel that this will
12 be hurtful to them, then I say they should have their day on
13 the Floor, too, within the limits that a busy Congress and a
14 complex legislative process permits.

15 Thank you, Mr. Chairman.

16 Mr. Hoyer. Pete Stark?

17 Mr. Stark. In a couple of minutes. Thank you,
18 Mr. Chairman. And I join with those who would praise Dick
19 Gephardt for the determination and hard work to keep this
20 issue before us.

21 We pass over very quickly the insurance reform section
22 of this bill, which does nothing but take every insurance
23 reform package you have seen, whether it is Ron Wyden's or
24 Chairman Dingell's or Lloyd Bentsen's, and broadens it to
25 every insurance company in the country, whether it is a

1 RPTS BURSTEN

2 DCMN MILTON

3

4

DEMOCRATIC CAUCUS

5

OF THE

6

HOUSE OF REPRESENTATIVES

7

ORGANIZATIONAL MEETING

8

Friday, July 24, 1991

9

10

11

12

13

The organizational meeting of the Democratic Caucus met
at 8:30 a.m., in the Hall of the House of Representatives,
the Hon. Steny Hoyer, chairman, presiding.

14

15

16

17

18

19

20

21

22

23

24

25

Health

Published by the Federation of American Health Systems, a trade association of for-profit hospitals.

NORTHERN DISCOMFORT: The Ills of the Canadian Health System

Here is a cool-headed, logical argument against using the Canadian health care system as a model for reform in the U.S. offered by a leading Heritage Foundation expert.

by
Edmund F. Haislmaier

Charles Coleman was 63 years old when his doctors told him that, unless he underwent coronary bypass surgery, he might die. In the four months that followed his diagnosis, Coleman's surgery was postponed 11 times; doctors at Toronto's St. Michael's Hospital cited a bed shortage in the Intensive Care Unit (ICU) as the cause of the delays. At one point, Coleman waited in the hospital 13 days before being discharged without surgery.

Although the surgery was finally performed, members of Coleman's family said that the long ordeal had so weakened him that he had become a "broken man" who had lost his will to live. He died eight days after his surgery.

This sad case, although dramatic, is not remarkable in Canada, where

the health care system has been fully nationalized for the past two decades. In a 1989 cover story entitled "Sick To Death," the Canadian news magazine *MacLean's* described Coleman's case, as well as numerous other examples of a national health care system in crisis. Dr. Phil Gold, then-chief physician of Montreal General Hospital, complained, "I'm living from hand to mouth and waiting for disaster each day.... I don't know when someone will die for lack of a bed or the proper equipment."

Yet in spite of its flaws, the Canadian system is the very model frequently proposed as a solution to the health care problems in the United States. Proponents of this view contend that the Canadian system provides access to health care for all its citizens at a lower cost than in the U.S., and with the same or better quality. Furthermore, they claim, a U.S. version of Canada's system could retain the freedom of choice currently enjoyed and valued by Americans, while hospitals and physi-

cians would be free to practice medicine with less interference or oversight from government regulators than many providers face today.

Presented this way, it is perhaps no surprise that Canada's system looks quite attractive to many Americans. Indeed, it registers considerable support in U.S. public opinion polls, far exceeding support for the existing system. According to a recent *Wall Street Journal*/NBC News poll, 69 percent of voters polled supported a Canadian-style system, including 60 percent of conservatives and 62 percent of those with household incomes exceeding \$50,000. Legislation now pending in Congress and several state legislatures would, if enacted, replicate the Canadian health system in the United States or in particular states. But in reality, the Canadian system is far less attractive than it appears at first glance.

Before examining why this is so, it is necessary to first dispel some basic misconceptions many in America hold about the Canadian system.

Similar provincial plans

To start with, the Canadian "national" health care system is not national in the sense of being funded or administered by a central government. The system is actually a collection of separate, although very similar provincial systems. Each of Canada's 10 provinces and two territories administers its own universal health plan and pays for most of its costs. Historically, the role of the Canadian federal government primarily has been to provide partial financing of the provincial health systems and to set broad structural guidelines to which the provincial plans must adhere if they are to receive federal financial support.

Those national guidelines were developed over several decades, leading to the establishment of similar systems in all Canadian provinces by 1971. In 1984, the federal guidelines

were revised and consolidated in the Canadian Health Act, which forms the basis of the current system. Under this act, provincial health plans are eligible for partial federal funding if they meet the following five requirements:

Universality. The plan must cover all residents of the province under uniform terms and conditions. For new residents, the waiting period prior to entitlement must not exceed three months.

Portability. The plan must provide continuous coverage for residents who are temporarily absent from the province and for individuals who move to another province until after they qualify for that province's plan.

Comprehensiveness. The plan must cover all hospital and physician services deemed "medically necessary" by the federal government. Other items can be covered at the discretion of the provincial plan under terms set by the provincial government. Such discretionary items include: outpatient services provided by non-physician practitioners (such as basic dental and eye care, prescription drugs, physical therapy and chiropractic services) and non-medically necessary services or amenities (such as cosmetic surgery or private hospital rooms).

Accessibility. The plan must provide all residents with reasonable access to care without financial barriers, such as out-of-pocket costs, and provide reasonable levels of compensation to physicians.

Public administration. The plan must be operated and administered by a non-profit, public authority accountable to the provincial government...

Doctors self-employed

While the Canadian federal and provincial governments control the financing of health care, they do not directly control or manage the delivery system. Most physicians are self-

employed and are paid on a fee-for-service basis according to fee schedules periodically negotiated between the provincial governments and physician's associations.

Similarly, most Canadian hospitals are in private hands, although virtually all of them are operated on a non-profit basis. Out of a total of 1,243 hospitals, only 61 (or fewer than 5 percent) are operated on a for-profit basis by private owners. These do not participate in the provincial plans, and as a result, their patients must pay all costs directly out-of-pocket. Most of these hospitals are really nursing homes. Another 49 hospitals are owned and operated directly by the federal government to serve patients in programs such as those for veterans, defense personnel, immigrants and prison inmates.

The remaining 1,133 hospitals are "public," meaning that they operate on a non-profit basis, participate in their respective provincial health plans and serve the general public. Of those, 57 percent are privately owned by either religious orders or secular voluntary organizations, with the remaining 43 percent owned by provincial or municipal governments.

The operating expenses of all public hospitals are financed by the provincial plans on the basis of "global budgets." This means that each hospital negotiates each year with the provincial plan for its total (global) operating budget for the coming year. The money then is disbursed to the hospital in periodic, lump-sum installments throughout the year.

Most of a hospital's capital budget, used for acquiring new equipment or facilities or upgrading existing ones, also is provided by the provincial government. This budget is kept

Edmund F. Haislmaier is a health care policy analyst at The Heritage Foundation, Washington, D.C.

separate from the hospital's operating budget. While hospitals may, and usually do, raise private funds for capital expansions through bonds or donations, those funds are controlled indirectly by the provincial governments as well. If the authorities do not agree with a planned capital outlay, they will refuse to provide the additional funds in the hospital's operating budget needed to staff or operate the new facilities or equipment. Thus, in practice, the provincial plans use the operating budget to limit the ability of hospitals to expand or offer new ser-

get reimbursed. This is because, as in all Canadian provinces, the government gives each hospital a fixed, annual (or "global"), budget, regardless of whom it treats. But the uninsured must pay for physician care out-of-pocket, or the doctors treating them must absorb the loss.

Various estimates put the uninsured population of British Columbia at between 2 percent and 5 percent, or 50,000 to 100,000 individuals. Were this figure applied to all of Canada, some 530,000 to 1.3 million people would be uninsured. And were this

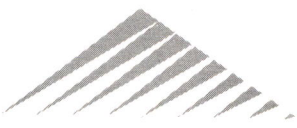
experts and laymen alike, is that Canada significantly limited the growth of health care spending once the government took control of health care financing. This leads to the assertion that the United States would achieve similar results if it adopted a Canadian-style system. In fact, however, this simplistic comparison of relative health spending as a percentage of GNP is misleading, and the popular conclusions drawn from it are invalid.

A closer examination of health care spending in both countries between 1967 and 1987, the most recent 20-year period for which data are available, shows why this is so. Between 1967 and 1987, real (inflation-adjusted) per capita health care spending increased at an average annual rate of 4.58 percent in Canada, versus 4.38 percent in the United States (both figures are in local currency). But GNP growth was, on the average, higher in Canada than in the United States during the same period. Between 1967 and 1987, again measured in local currency, Canada's real per-capita GNP grew 74 percent, while the real growth in U.S. per-capita GNP was only 38 percent. Canada, in short, has done no better than the United States in controlling the growth of health care costs, but our northern neighbor's health care/GNP ratio has remained lower because of its rapidly rising GNP level.

When figures for both countries' real per-capita health spending are converted into the same currency, they show that Canada has consistently spent about 75 percent of what the United States spends on health care, both before and after the introduction of universal government funding in Canada. Why this disparity exists is a matter of some speculation. What is clear, however, is that the introduction of a government-financed health system in Canada generated no measurable change in the real rates of Canadian health care spending relative to that in America.

Perverse results

While Canadian federal and provincial governments have failed to control the growth of health care spending by any meaningful measure, their attempts to do so have generated perverse results. This is due to how the system pays doctors and hospitals.



A recent study estimates 260,000 Canadians are currently waiting for major surgery.

vices. By exercising their "power of the purse" in these ways, the provincial governments seek to control total health spending. In the delivery of health care, however, doctors and hospitals still retain considerable discretion to run their facilities and treat their patients as they judge best.

Finally, the Canadian system is not, as many in the United States assume, universal in the sense that it covers all medical care or health spending. Nor, in fact, are nationalized health systems in other countries universal in this sense either. Of total health care spending in the United States, 42 percent is funded through federal, state and local governments. The share of Canada's health spending funded through its federal and provincial governments is 74 percent. This point is worth noting because virtually all proposals to replicate the Canadian system here would, in fact, significantly exceed the scope of the current Canadian system, entailing government funding of 90 percent or more of U.S. health spending.

What might come as the biggest surprise to Americans is the existence of uninsured Canadian citizens. In the two provinces that charge health care premiums, Alberta and British Columbia, citizens who fail to pay technically are uninsured. While Alberta acutely reimburses hospitals and doctors anyway for treating uninsured patients, as do many U.S. states, in British Columbia only the hospitals

figure then transposed to the U.S., some 5 million to 12.5 million Americans would be uninsured – this is still a significant one-sixth to one-third of the present U.S. uninsured population. The British Columbia Medical Association estimates that each year its member doctors provide \$15 million to \$50 million in uncompensated care to the uninsured.

Mythology of cost control

What its U.S. proponents find most attractive about the Canadian system is that it appears to provide universal health insurance coverage at a lower cost than our present system, which leaves 31 million Americans uninsured.

In the early 1960s, before Canada moved to a national system, it was spending a slightly higher percentage of its GNP on health care than was the United States, roughly 6 percent versus 5.5 percent, respectively. After 1971, however, when the main elements of Canada's system were introduced in all provinces, costs began to diverge, with Canada spending considerably less of its GNP on health than its southern neighbor. In 1989, U.S. health care spending was 12 percent of its GNP. In contrast, Canada's health care spending was only 9 percent of its GNP.

Simplistic comparison

The simple conclusion, drawn countless times from these data by

The Heritage Foundation Consumer Choice Health Plan

The Heritage plan, similar in many ways to the consumer-driven Federal Employees Health Benefits Program, would use the discipline of the free market (choice and competition) to control costs. By eliminating the tax exclusion for employer-provided health benefits and replacing this tax break with individual tax credits based on income and medical expenses, the Heritage plan would give all Americans access to medical protection — including those who currently are uninsured. The plan would be budget neutral.

For more information on the Heritage Consumer Choice Health Plan, the following studies can be obtained from Heritage's Publications Department:

- "A Policy Maker's Guide to the Health-Care Crisis:"
 - "The Debate Over Reform," Talking Points Part I
 - "The Heritage Consumer Choice Health Plan," Talking Points Part II
 - "What's Wrong With America's Health Insurance Market," Talking Points Part III
- "Why the Maryland Consumer Choice Health Plan Could Be a Model for Health-Care Reform," Backgrounder #902
- "Problems in Paradise: Canadians Complain About Their Health Care System," Backgrounder #883
- "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Backgrounder #878
- "As Washington Dithers, States Reform Health Care," Backgrounder #868
- "Comparable Worth for Doctors: A Severe Case of Government Malpractice," Backgrounder #855
- "Perception vs. Reality: Taking a Second Look at Canadian Health Care," Backgrounder #807
- "The Pepper Commission's Misguided Solution to America's Health Problems," Backgrounder #793
- "Using Tax Credits to Create an Affordable National Health System," Backgrounder #777
- "Making Long-Term Health Care More Affordable," Backgrounder #755



214 Massachusetts Avenue, N.E.
Washington, D.C. 20002
(202) 546-4400

Ironically, the same payment methods that cause the problems are viewed by many as one of the system's most attractive features because of the freedom they allow both patients and providers. Patients may choose from any doctor or hospital participating in the provincial plan. Although doctors and hospitals must accept government fees or budgets, they are free to manage their facilities and practice medicine as they see fit, without the detailed oversight and stifling bureaucracy that characterizes the U.S. Medicare, Medicaid and private insurance systems, or even some other nationalized systems.

In contrast to some other nationalized systems that pay doctors flat salaries or a fixed annual amount per patient, a Canadian doctor is paid a fee for each service provided, with the schedule of fees negotiated annually by the provincial government and the provincial medical association.

The problem, however, is that in any fee-for-service system where patients do not purchase care directly, or even buy their own health insurance, there is no financial reason for them to question physician decisions. This leaves doctors free to compensate for reduced government-set fees by increasing the volume of services they provide. According to a recent article in the Massachusetts Institute of Technology's *Technology Review*, Canadian provinces cut physician fees by 18 percent between 1972 and 1984, but in an amazing coincidence, doctors' total billing claims rose by 17 percent during the same period. When Quebec froze medical fees from 1972 to 1976, causing a drop of 9 percent in their real-dollar value, doctors increased their billings by 8.3 percent. Similarly, in spite of a 1984 freeze on medical fees in Alberta, the province's doctors increased their incomes by 12 percent that year. "Hit with a fee cut, doctors simply see more patients and provide more services," the MIT report concluded. Most of these services are unnecessary and simply push up health care spending needlessly.

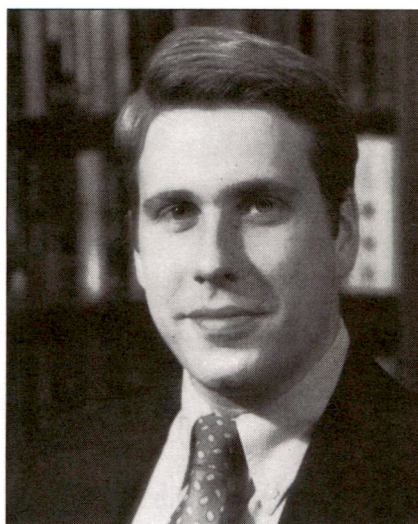
Obsolete equipment

Confronted with this new problem, at least one province, Quebec, has responded by placing limits on the amount it will pay individual doctors each year – strongly discouraging them from providing additional treat-

ments. But it is hard to see how this differs, in practice, from simply making doctors salaried employees of the government.

Other Canadian provinces are now either considering or introducing similar changes. Some are also looking at adopting U.S.-style utilization review and control methods. But each of these trends will increase bureaucracy and drastically curb the vaunted clinical freedom of Canadian doctors.

Canadian doctors and hospitals see their clinical freedom restricted in other ways, particularly as a result of global budgeting for hospitals and



Heritage Foundation's Haislmaier

government controls over hospital spending on capital improvements. Many Canadian hospitals were built in the 1950s and 1960s. But since the nationwide health system was put into place in 1971, hospitals have found it increasingly difficult to obtain the funding they need to replace obsolete or worn-out equipment or facilities. In essence, Canada's hospitals have been living off their existing capital for 20 years, and more of them are gradually exhibiting the obsolescence and decay found in many British National Health Service hospitals.

The provincial governments also sharply restrict the availability of medical equipment outside of hospitals, forcing doctors to conduct most procedures in a hospital, where they can be both more closely monitored and controlled. This practice produces perverse results as well. "The dramatic shift to outpatient diagnostic testing and outpatient surgery that has taken place in the United States has not been replicated yet in Canada,"

observed Ed Neuschler of the Health Insurance Association of America in his study of the Canadian system. "For example, all Canadian computerized tomography (CT) scanners are located in hospitals and, in Ontario, this has been made a legal requirement. Keeping major medical procedures in hospitals, which are under their direct budget authority, allows provinces to better manage total costs by controlling supply." In other words, to control physician practice patterns and patient demand, Canada forgoes the potential cost savings and quality improvements these new outpatient technologies would otherwise generate in a true free market.

These practices also have an adverse effect on patient care. For example, magnetic resonance imaging (MRI) machinery is now widely used in the United States in the treatment of joint, spinal and neurological disorders; over 2,000 MRI machines exist in U.S. hospitals, clinics and diagnostic centers. But Canada possesses only 15 MRI scanners, and all of these are located in hospitals, making these tests much more difficult to obtain...

Maple leaf drag

As with any nationalized health system, when unlimited demands for perceived "free" care collide with limited government budgets, shortages result and more people must take a number and wait for treatment. The resulting problems and horror stories have provided much grist for the press.

The same *MacLean's* article that related the story of heart patient Charles Coleman also reported: "Hospitals in some cities have had to institute unusual, and sometimes humiliating, economic measures. Patients in the maternity ward of one general hospital find it is strictly BYOD – bring your own diapers – and pillows as well; while elderly patients in some Montreal hospitals are being kept in diapers because nurses do not have time to help them go to the bathroom." At the same time, at New Brunswick's Moncton Hospital, "some patients are kept in hallways and even closets, while a total of 2,300 people were on the waiting list for surgery last month."

Waiting lists are now endemic in Canada's health system, and a recent study estimates 260,000 Canadians are currently waiting for major surgery.

In April 1989, one Ontario paper reported, "There are currently 1,600 people in Ontario waiting for heart surgery and the list is steadily increasing." The same month, another Ontario paper published the news that "Kitchener-Waterloo Hospital will be closing at least 43 beds, laying off or cutting back the hours of at least 70 staff members, capping the hemodialysis program, and discontinuing lens implant procedures at the hospital."

From the *Winnipeg Free Press* came the report in July 1989 that, "Doctors and nurses at Brandon General Hospital lashed out yesterday at bed closings that have left 91

been conducted, they only confirm what quick, back-of-the-envelope calculations yield. Present U.S. health spending is over \$600 billion per year, of which the federal, state and local governments account for 42 percent, or roughly \$250 billion. Thus, expanding the total government share to the 74 percent found in Canada would necessitate about \$190 billion per year in new government spending. Expanding the government share to around 90 percent or more, as would occur under most pending legislation to adopt the Canadian system, would push total new government spending into the \$300-billion-per-year range.

examples. There is already one graphic example in the U.S. health care system of what would happen nationally with a Canadian-style system: namely, the medical system run by the Department of Veterans Affairs. That system labors under chronic budget problems, and constant restrictions and special interest requirements imposed by Congress. In fact, congressional interventions have kept any obsolete V.A. hospitals from being closed over the past 26 years.

Alternatives to the Canadian plan

There is a lesson in the Canadian experience that Americans should take to heart.

In reforming our own system, we should avoid confusing means with ends. All the attention focused on the uninsured in the United States has led many to seek universal health insurance coverage through a nationalized system. Yet the real goal should be to provide all Americans with adequate medical care. Health insurance is only one of several means of achieving that goal, and many times it is not the best means.

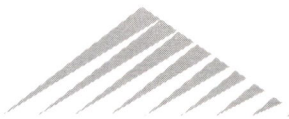
Rather than instituting a government-run system of universal health insurance, Americans should pursue reforms designed to ensure that all citizens have access to adequate medical care. Such reforms have two fundamental objectives:

First, to empower consumers by giving workers and their families direct control over the money used to purchase their medical care and insurance, thus unleashing market forces and consumer choice to control health care costs and bring efficiency to the system.

Second, to restructure existing health care tax policies and government programs to provide the poorer and less healthy members of society with the extra purchasing power they need to obtain necessary medical care and insurance in a freely functioning market.

Pursuing reforms based on these principles offers the best hope for America to create not only a better and less expensive health system, but also a system that achieves the goal that has eluded Canada: affordable access to medical care for all its citizens... ■

Reprinted and edited with permission from The Heritage Foundation's Policy Review and Backgrounder.



What might come as the biggest surprise to Americans is the existence of uninsured Canadian citizens.

patients, including cancer victims, waiting up to six weeks for urgent surgery. Most of the patients have cancer of the breast, large bowel, or lungs, chief of staff Dr. Michael Taylor said. He blamed the funding woes and bed closings on a Health Department policy introduced by the former government that forbids deficit-financing and forces hospitals to balance their budgets."

On September 14, 1989, the *Toronto Sun* reported, "The Princess Margaret Hospital has announced it won't accept new cancer patients requiring radiation treatment for a six-week period starting September 30 to clear up a 300-patient backlog." Last year, the *Edmonton Journal* stated, "The only hospital doing cardiovascular surgery in northern Alberta now has 210 adults and children on its waiting list. The average wait is six months, although some people have been waiting as long as a year, said a hospital spokesman."

\$190 billion in new taxes

If all of this is not enough to dissuade U.S. policy makers from instituting a Canadian-type system, the projected costs definitely should be. While several detailed analyses of the cost of adopting a Canadian-type system in the United States have recently

Economists Gary and Aldonna Robbins have estimated that funding such a total health care nationalization program would require either: increasing the combined employer-employee payroll tax from its current rate of 15 percent to 29 percent; raising income tax rates across the board by 14 percent, or imposing a new national sales tax of 10 percent.

Furthermore, the U.S. political structure is fundamentally unsuited to effectively administering a national health system like that in Canada. Unlike other countries with nationalized health systems, the United States does not have a parliamentary system of government. The U.S. system not only separates the executive and legislative functions, but even within the legislative arena, congressmen and state legislators more closely represent the narrower interests of their constituents and are much less subject to party discipline than are their parliamentary colleagues in other countries.

Because of these significant political differences, any national health system in America likely would quickly degenerate into pork-barrel politicking and legislative micro-management. Indeed, one does not have to look to obsolete military bases, farm subsidies, public works programs or dubious research projects to find

✓ Copy to ^{health} care
Hans Kuttner

Document Originally
Attached to
Following Page



OFFICE OF THE VICE PRESIDENT
WASHINGTON

September 8, 1992

Harvey L. Lerner, M.D.
215 East Main Street
Smithtown, NY 11787

Dear Dr. Lerner:

Thank you (belatedly) for your letter of July 11 and for enclosing your proposal for Health Care Restructuring.

I think we're in considerable agreement in principle -- though how to get from here to there is a difficult question. In any case, I've asked Richard Porter, Counselor to the Vice President, who's quite expert on the health care issue, to take a careful look at your proposal. Feel free to contact him directly at 202/456-6640.

Thanks again for writing.

Sincerely,

A handwritten signature in blue ink, appearing to read "Bill Kristol".

William Kristol
Chief of Staff

cc Richard Porter

7/16

SMITHTOWN MEDICAL SPECIALISTS, PC

MELVYN BRUCKSTEIN, MD RICHARD S. GOLD, MD
HARVEY L. LERNER, MD

DIPLOMATES, AMERICAN BOARD OF INTERNAL MEDICINE

215 EAST MAIN STREET
VILLAGE OF THE BRANCH
SMITHTOWN, NEW YORK 11787

(516) 265-5858 FAX: (516) 265-5756

11 July, 1992

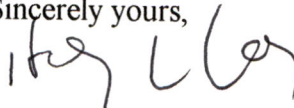
William Kristol
Staff of Vice President Daniel Quayle
Senate Office Building
Washington, DC

Dear Mr. Kristol:

I am sending the enclosed proposal to you at the suggestion of my friend, Professor Bernard Semmel of the graduate division of CUNY, where he has been appointed successor to one Professor Gertrude Himmelfarb. That is by way of getting my foot in the door.

The proposal speaks for itself. I believe you will find it unique. Its strength is the description of an affordable marketplace for health care, something which no other health care proposal addresses. This plan allows for freedom of choice for individual Americans, professional freedom for providers, affordability for consumers, and decreased health care expenditures for our nation. Please read on!

Sincerely yours,



Harvey L. Lerner, MD

A Proposal for Health Care Restructuring

Any system devised to reorder the financing of health care in the United States should address these priorities:

it should be affordable, for individuals and families, and also for the nation

it should be available to everyone

it should give the consumer freedom of choice

it should preserve or strengthen professionalism

I believe the proposal outlined below meets those specifications better than any other I have seen.

Introduction

The most important reason for rising costs in health care is the insatiable demand for services. When services are paid for by insurance programs, it is always "other peoples' money " that is being spent by the individual consumer; so long as this is true, everyone will want "the very best" for himself.¹ That is only rational behavior --human nature, one might say.

The result is the perpetually increasing demand for care.² In our current system, where services are substantially insurance-covered, providers are under no pressure to compete with one another based on price or on cost-effectiveness; instead, to attract patients, they compete based solely on the quality of their care, or the quality of their care as the public perceives it to be. They will make massive investments in technologies and procedures, proven and unproven, if only to maintain a seeming edge in quality over others; obviously, the competition will respond in kind.³ In fact, reimbursements are usually configured to compensate for services --therefore, the more, the better.⁴ This is not unlike cost-plus defense contracting.

¹In this paper, in every instance, "he" should be taken to mean "he or she or they."

²Especially the costliest services, hospital, nursing home, and laboratory/imaging, which tend to be 100% covered

³Duplication of cardiac surgical facilities in hospitals is the first example that comes to mind.

⁴This is still true, although in a more limited way, for hospitals under DRGs; hospitals that provide more service are rewarded with higher DRGs.

There are two ways to control or limit such runaway demand.

- One way is to micromanage from above in order to limit or to ration utilization of services, i.e., to impose a Soviet style system of controls and guidelines. Most proposals to reform health care essentially do just that, and also skew the field radically in favor of managed care systems, where important decisions are no longer made within the profession. The result is bureaucracy, inefficiency, corruption, and professional demoralization.⁵
- The other way is to create a market.

We often hear that a market won't work because the poor will be unable to participate in it, and besides that, a market would annul the concept of insurance. That does not have to be the case. A marketplace that satisfies these criticisms is the essence of the program presented in these pages.

The Plan

Begin by abolishing all existing health insurance.

In its place, install a system which relates the income of the insured to the extent of insurance coverage he is permitted, under any circumstances whatever, to buy.

Include all health costs in this program.⁶

Increase coverage as families reach "catastrophic" levels of health-related expense.

The identity of the premium-payers is a separate issue, although one may be sure that the total cost for all payers together will be lower.

Free the providers of price control, but establish quality minima.

Structure the payment system so that the provider is not paid until the recipient of services has made his co-payment to the insuring body.

⁵An effect yet to come is a decrease in the number of self-starters entering medicine. One has only to look at the example of the schoolteachers of America to witness the deprofessionalization that occurs when people surrender control over their own work.

⁶This point is not essential to the overall plan. Some kinds of psychiatric services, for example, could be excluded.

Advantages of the Plan

There is some cost out-of-pocket for every health care item or service, none excepted (i.e., including hospital services); this creates a market.

People at every income level will have the same access to service and will feel "the pinch" appropriate to their income level.

The demand for services will decrease, because the intelligent consumer will not pay for services that are not cost-effective.

Consumers of health services will begin to look at what they are getting and will become more discriminating. That will raise people's expectations and the quality of services better than an army of regulators.

Providers will become price-competitive and improve efficiency, lowering the total cost of services to the nation. It will cost the consumer less out of pocket to go to a provider who offers the same service for less.

It does not tell the providers what they may or may not do. A mushrooming and invidious set of controls now envelops physicians, hospitals, and others. It bodes to deprofessionalize health care because compliance with rules becomes more important than doing the work.

It eliminates the need for a large regulatory bureaucracy.

It allows for simple computerization of payments, with inputs consisting only of health care bills, last year's net income, IRS-verified, and receipt of copayment.

It permits government to influence the degree of medical inflation by simply modifying the extent of allowable coverage. Similarly, it permits government to adjust for differences in utilization by different income levels and to eliminate those differences, if that is desired, by changing the extent of permitted coverage.

It should be very simple to run a pilot study to see how well it works.

Explanation by Illustration

My experience in presenting these ideas tells me that illustrating them works faster and better than trying to explain them in the abstract. (The numbers I have chosen

are pure guesswork and for example only; working out the particulars would require actuarial study by health economics experts):

Right now, anyone with enough money (and good health) can buy major medical insurance that covers, say, 80% of outpatient costs and professional fees, and 100% of hospital services.

Some families have drug insurance with 100% coverage or flat fee payments for medicines, whatever the choice of drug.⁷

This plan would place legal limits on the percentage of costs that insurance would be allowed to cover. It would apply to everyone, and the limit would be income-dependent, so that, by mandate, wealthy people would get lower percentage coverage than poor people would. For instance, suppose one allowed families with incomes of \$0 to \$30,000 to buy insurance that covered (and was limited to) 95% of all health costs; families with incomes of \$80,000 to \$100,000 to buy insurance that covered 80% of all costs; and families with incomes of \$1,000,000 to buy insurance that would be limited to 35% of all costs. (Sorry to repeat: these numbers are for illustration only; the first approximation to ideal numbers would emerge after appropriate modeling by economists.)

Each family would have free choice of where and how to get health care.

A person with 95% health coverage spending a day in the hospital with a day rate of \$500 would be expected to pay 5% of \$500, or \$25; someone with 35% coverage would now pay 65% of that same \$500, or \$325. The rich pay more and the poor pay less; everyone pays an amount adjusted to create equal unpleasantness at every level of income. The same person going to a hospital with a day rate of \$1,000 would be paying twice as much out-of-pocket, no matter what his income level.

Ideally, services to each income level would equalize. If not, plan administrators or Congress could change the coverage percentages for each level of income, if that were the public policy decision.

A patient would then ask himself, at every moment, "Is the incremental cost of a test or a therapy worth to me the added, out-of-pocket part of the cost I must now pay for it?"

⁷Obviously, such arrangements result in choice of hospitals without respect to their charges and of drugs without respect to their efficacy for the cost. There is a lot of occult discretionary spending here. In addition, because hospitals need compete, in this system, only on quality, they are driven to become "better" and "better" by purchasing more and more technology, irrespective of market-demonstrated benefit.

Many truly optional or "defensive" tests and many treatments of dubious efficacy (such as some long-running physical therapy) would be difficult for the patient or the doctor to justify, if someone visible (and not abstract, like an insurance company) were paying money for them. Services that were "worth" the cost would continue to be demanded, because most of us want to get better and are willing to pay for what might be necessary.

A person with high blood pressure would reflect on whether the newest and most expensive choice of medicine was truly what he wanted, i.e., whether the difference mattered enough to him to pay more dollars for it than the older medicine, which is perhaps 80% as effective (figuratively) and 10% as expensive. Unlike what has been proposed in many health care reform proposals, in this plan he would retain absolute free choice, provided he paid his uncovered portion of the charge. In every instance, the incremental charge would be smaller for a poor person than for a rich one. If the numbers that were set discouraged one class of people from optimizing health vis a vis another class, those numbers could be changed next round.

One physician might spend ten minutes with a patient and charge \$25; another might believe it appropriate to spend an hour for the same problem and charge \$150; each would be allowed to do so, and the patient could choose whomever he wanted to see, understanding it would cost him more to see some doctors than others, or to use some surgeons or hospitals.⁸

Physicians and other health care providers could organize themselves into prepaid groups or work on the basis of fee-for-service, all on level competitive ground. The public could shop price versus relationship in the same way it chooses between Wal-Mart and the corner grocery. In due time, the marketplace will identify how many of each category it wants, and the survivors will emerge, as they should. The surviving providers would tend to be the most efficient ones and/or those with the highest quality, as judged by the consumer --and not by the regulator.

Doctors could continue to practice as they saw fit and hospitals to equip themselves as they wish. Competition between providers would be based on both quality and cost. There would be no undertrained and self-perpetuating cadre of health police, such as is now burgeoning.

⁸This is now impossible under Medicare and managed programs where the doctor or managed care plan is incentive-driven to provide quick, high volume service and to reject clientele who will consume more time; likewise, net income is higher when overhead and amenities are minuscule; do we want that?

The American people do have every right to establish minimum standards for quality or to expect the professions to do just that.⁹ The publication of outcome results would help to maintain a rational market; perhaps, also, advertising of health services should be regulated, probably by the professions themselves.

The added competitiveness under this plan will have some unexpected salutary effect on medical pricing, which we all recognize has been high. For example, if insurance companies now "allow" a \$5,000 fee for an operation, many surgeons will "accept" the 80% insured payment of \$4,000 and not bill for the balance, even though that is most often illegal. As a result, no new surgeon arriving in town ever undercuts the \$5,000 fee and charges \$2,000, because he can always make at least that same \$4,000 as did the other surgeon, without imposing any out-of-pocket expense on the patient.

Under the plan proposed here, there are no "allowed" charges. Every fee involves a mandatory copayment, the size of which is related to affordability. In that setting, competition will force fees down where there is room for them to be lowered (surgery, medical procedures, laboratory, XRay). It will preserve or raise fees for primary care, where overhead is high, paperwork brutal, and political influence in medical circles low, and where the regulatory agencies, under surgical pressure, have undermined the new relative value scales to the detriment of the family doctor.

Also, wherever professional overhead is high, fees will be higher, for market reasons, and vice-versa; there will be no necessity for agencies to approximate ideal overhead expenses, as they now must for RBRVS under Medicare. They seem to have trouble doing that right.

A hospital might choose to offer bone marrow transplantation as a service, in order to enhance its reputation and to make itself the definitive center for cancer care in its region, knowing that by doing so it would drive its daily bed cost up¹⁰ --and therefore make people with non-cancer diagnoses or lesser illnesses, like bleeding ulcers or pneumonia, somewhat less likely to choose it for their own admission. That would be both a professional and a "business" decision for the hospital's board to make, and it would compare with similar decisions made by businesses and corporate boards all over free-enterprise America; it would not be a decision made by a public board with a political agenda.

⁹The medical profession would have to be given the legal authority for tough self-regulation.

¹⁰It might be necessary to require hospitals to average their costs and not charge a higher day rate for some illnesses than others.

If an illness turned out to be expensive and cost someone, say, 5% of his annual net family income, the percentage of "coverage" would be adjusted upwards for the next increment of income. For example, the poor family insured for 95% of costs below 5% of annual income might be covered 98% for costs running from 5% to 10% of annual income and 99.5% for costs in excess of 10%; the family covered for 80% might be covered for 93% until the next break point, etc. There should be nothing that makes necessary services unattainable.

The degree to which services would be insured across the board, at all levels of income considered together, would be a recurring public policy issue. More insurance at every level would lead to a higher percentage of the GNP spent for health, and less insurance would mean a lower percentage. Government would make a policy decision based on the usual priorities for the expenditure of our national wealth. Probably, we would opt for the best we could afford. The advantage of this plan is that the total expenditure would be insurance-coverage sensitive on a national basis, much as inflation and money supply are interest rate dependent, and thus subject to policy decision.

There is at least one important caveat. A provider might raise its (his) fees at will, collect the covered or insured portion, and then omit to charge for the balance that is directly owed by the patient. This kind of cheating is commonplace in the present major-medical-insured marketplace.

To avoid this problem and to keep the whole system running in accord with its design, the patient must be required to pay his portion directly to the insurer (or the government? the IRS? --ideally, it could be included in the tax bill, but that concept terrorizes me and probably most Americans), after which the insurer would release the entire payment owed to the provider. Of course, such a mechanism creates a disincentive for insurers to collect from patients. They will already have the premiums; why now collect 23 cents and then pay out \$1.00? Perhaps if the insurers/collectors were chosen by the providers . . .

Obviously, premium payments, if they are not averaged, would be much higher for poorer people than for richer. This concern should be offset by the fact that out-of-pocket costs for rich people would be greater than for poor people. This is only as it should be.

Problems with the Plan

Some provision will have to be made for people with no income whatever.¹¹

It does not mandate how premiums are to be paid. Inasmuch as income levels are already inputted into the format, public policymakers would have to decide on the issue of tax-deductibility of the premium cost for individuals, whether included in employee benefits or not.

People now working in health care supervision would have to be retrained to do something useful.

It would impede the growth of some technology. I love high technology and do not believe that markets impede its growth. Rather, I suspect that this plan would stimulate the growth of a new, rational, "efficiency technology."

Conclusion

It is very difficult for people who are peripheral to the economics of health care to weigh proposals that purport to reform health care.

My own work provides me with daily examples of overconsumption of services because they are overinsured (not unlike auto collision, to give anyone a familiar reference point): "Doctor, please do everything for my mother [who is completely demented from Alzheimer's disease and needs to be comfortable, not to be poked at or invaded]", "Why can't I have an MRI for my dizziness? I'm covered."; or doctor to patient: "I think some physical therapy might help your shoulder; it can't hurt [it might/might not help; the benefits/costs need to be explained explicitly; patients would learn to ask if they had to pay some more]", "Just a few lab tests . . .", etc., etc., etc. Add to this the sometimes extravagant purchases by hospitals just to keep up, etc., etc.

The marketplace is a natural institution because it satisfies the human desire for freedom of choice. The problem has been to construct a marketplace that would not exclude the poor. I believe that the concept I have offered embodies the priorities of affordability and professionalism and is fair to both consumers and providers, while allowing the nation to conserve its resources by spending less.

¹¹I have a companion proposal for welfare reform which solves this and which melds perfectly with it. Briefly, in place of all existing welfare programs, give each family in the United States, rich or poor, a subsistence grant, say \$20,000. Adjust the taxes of everyone to meet the cost --in essence, income redistribution, to a degree. Now, take care of yourself, pay taxes, and the first dollar earned becomes a dollar you keep, less taxes. The copayments for health care would then be from this same subsistence payment.

Please call me or write to me if any clarification is required.

Harvey L. Lerner, MD
215 East Main Street
Smithtown, NY 11787
(516)265-5858
FAX:(516)265-5756