“Care is rationed in our current system in several ways. The public policy issue is not whether we ration care, but can we find a more rational method of allocating resources?”

Bill Custer, Employee Benefit Research Institute

“Most countries have found it difficult to decide what not to cover, so they have pushed the decisions down to local levels. True rationing at the federal level requires a truly defined and managed health care delivery system nationally.”

Roger S. Taylor, PacifiCare Health Systems

“The public has a lack of trust in the leadership, and most people are unwilling to make sacrifices because they are not convinced it is needed and that it will help others. The public perceives the health care system as a complicated system full of black holes, and so they are not convinced that making cuts in some areas will help others.”

John Immerwahr, The Public Agenda Foundation

“Because medicine is as much art as science, rationing medical care by guidelines and gatekeepers may be the most direct route to quality. It may be time to worship rationing as both the route to quality and as an economic necessity.”

Dallas Salisbury, Employee Benefit Research Institute

“A global budgeting system is the only cost containment alternative that would involve the type of systemwide restructuring necessary to achieve the results that the American people expect but with the checks and balances and opportunities for involvement that will ensure their support.”

Karen Ignagni, AFL-CIO

“Coordinated action by all payers would impose a discipline on total spending that no one payer could command. Providers would be forced to reduce costs rather than shift them.”

Larry Atkins, Winthrop, Stimson, Putnam & Roberts

“If we are going to explicitly decide what to cover and what not to cover and how much, who is going to get to make these decisions? If we just turn it over to the medical profession, then the values that will dominate those choices are those of white, middle-aged, upper-middle class men.”

Joshua Wiener, The Brookings Institution

“The Oregon Plan eliminates the implicit tools of health care rationing imposed by states, businesses, and the federal government today, and replaces them with an open, clearly defined, resource allocation process that combines considerations of clinical effectiveness, social value, and fiscal responsibility.”

Mark Gibson, formerly with the Oregon State Senate President’s Office
### Table of Contents

**Research Topic: All-Payer Rates**

**How Does Japan Do It? Universal Insurance Coverage**  
John Immerwahr, The Public Agenda Foundation/Villanova University  
Introduction  
Public Perception (Table 1, Table 2)  
Principles of Rationing  
Guidelines (Table 3)  
Rationing Health Care in Other Countries  
Roger S. Taylor, PacificCare Health Systems  
Introduction  
Defining Rationing  
Allocation  
Rationing in Other Countries  
Coverage, Cost, and Quality  
Conclusion  
References  

**Health Care Rationing: The Public’s Perspective**  
Selwyn Feinstein, EBRI Fellow  
U.S. Rationing  
Other Countries  
Public Perception  
Proposals for Rationing  
Conclusion  

**Health Care Expenditures**  
Table 1, Number and Percentage of Persons Covered  
Table 2, Number and Percentage of Persons Covered  
Table 3, Acceptable and Unacceptable Limitations  
Table 4, Health Care Expenditures  

**Issues in Global Budgeting**  
Karen Ignagni, AFL-CIO  
Introduction  
Global Budgeting (Chart 1)  
Design  
Other Considerations  

**All-Payer Rates: Bringing Order to the Health Care Market**  
G. Lawrence Atkins, Winthrop, Stimson, Putnam & Roberts  
Introduction  
Definition  
The Rationale  
Effectiveness (Table 1)  
Issues  

**Effectiveness** (Table 1)  

**The Use of Gatekeepers and Fee Schedules to Allocate Resources**  
Cynthia K. Hosay  
The Segal Company  
Introduction  
Physician as Gatekeeper  
Fee Schedules  
Conclusion  

**Explicit Rationing/The Oregon Proposal**  
Mark Gibson, Oregon State Senate President’s Office  
Introduction  
Resource Allocation  
Identifying Costs  
Conclusion  

**Appendix A. The Oregon Health Plan**  
Overview  
Evolution of the Problem  
The Need in Oregon  
Underlying Premises  
Policy and Principles  
Statutory Framework  
How the Plan Works  
Funded Benefit  
Cost Containment  
Appendix A 1. Prioritization Process  
Appendix A 2. Standard Benefit Package  
Speakers and Participants  

**Tables**  
Table 1, Which Statement Do You Tend to Agree with Most?  
Table 2, Who Is in the Best Position to Limit Health Care?  
Table 3, Acceptable and Unacceptable Limitations  
Table 1, Number and Percentage of Persons Covered by Health Insurance, 1991  
Table 2, Number of Persons Covered by Health Insurance, 1955  
Table 3, Percentage of Government Subsidies to Health Insurance Schemes  
Table 4, Health Care Expenditures as a Percentage of National Income  
Chart 1, Spending as a Percentage of Gross Domestic Product  
Table 1, Comparison of Hospital Cost Increases in All-Payer and Competitive States  

**Conclusion**  

**Bibliography**  

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April 1993 • EBRI Issue Brief
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Masataka Kohda has served as the president of The Pension Welfare Service Public Corporation of Japan since 1988. Prior to this position, Mr. Kohda worked for the Japanese Ministry of Health and Welfare (MHW) for 34 years. Among the positions he held at the MHW was vice-minister; director-general, health insurance bureau; director-general, minister’s secretariat; director-general...
children and families bureau; and councillor for health insurance. Mr. Kohda is a graduate of Tokoyo University.

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Rationing: Another Contradiction in the Health Care Debate

By Selwyn Feinstein, EBRI Fellow

Despite talk of momentum, realities continue to clash in the health care debate.

• Americans abhor health care rationing. Yet health care is being rationed in the United States today.
• Health care strategists overwhelmingly agree that the system must be reformed. Still, they argue over almost every detail of how that reform should be shaped and who should shape it.
• The public concurs on the need for change. But it asserts a view of the problem that is distinctly its own and wholeheartedly approves of the medical treatment it receives now.

Such were the conflicting realities presented in stark contrast at a policy forum sponsored by the Employee Benefit Research Institute Education and Research Fund (EBRI-ERF) in Washington, DC on Dec. 1, 1992. The forum was entitled, “Rationing: Making Choices and Allocating Resources in the Health Care Delivery System: Implications for Access, Quality, and Costs.”

The contradictions, voiced as President-elect Bill Clinton was preparing to take office, underscore the challenges the new administration faces in its determination to establish universal health coverage and bring costs under control.

“The United States allocates more of its resources to health care than any other country in the world,” with outlays rising twice as fast as general inflation, observed Roger Taylor, formerly of The Wyatt Co.¹ Yet, he said, “the United States falls short of our major economic competitors in many of the statistical measurements of population health.”

Moreover, one in six Americans under age 65 has no health insurance or publicly financed health assistance, EBRI has found. Equally distressing, as many as 30 percent of certain types of medical procedures may be inappropriately or unnecessarily performed in the United States.

Health care is being rationed in the United States today, Bill Custer of EBRI asserted. This is so even if policy strategists have yet to reach accord on what the term means, or, as Dallas Salisbury of EBRI suggested, the term is becoming a red flag, as in, “We can’t do that. That would be rationing.”

Custer has defined rationing as any mechanism that allocates scarce resources and denies some level of care that might be expected to be beneficial. He analyzed the rationing process in the EBRI Issue Brief, “Rationing: Resource Allocation in the Current Health Care Delivery System,” which he presented at the forum.² Inherent in the definition is a separation in the allocation process between the decision maker and the person who could benefit from the care. As our system has developed, Custer said, this gap has widened.

Taylor suggested, however, that in today’s “nonsystem,” it is difficult to identify that gap; individual consumers may do their own limiting based on cost and ability to pay. “People ration themselves,” he stated.

Joshua Wiener of The Brookings Institution questioned whether the term should include people who do not pay for the care they receive. This distinction becomes pertinent, he said, if the United States is introducing rationing or it already exists.

Care is rationed in our current system in

¹ At the time of the policy forum, Taylor was national leader, health care, with The Wyatt Company. Since that time, he has joined PacifiCare Health Systems as senior vice president and chief medical officer.

several ways, said Custer. It is rationed by ability to pay, which usually means access to health insurance; by decisions of doctors and hospitals, often a function of economic incentives and regional preferences; and by federal, state, or local government decree. The issue then becomes can we find a more rational way to ration care?

Uninsured Americans, most in working families with annual incomes of less than $20,000, receive fewer health care services and lower quality care than those with health insurance, generally because the uninsured must seek their care in overburdened hospital emergency clinics or outpatient departments.

Medicare for the elderly and Medicaid for the impoverished, the two principal government insurance programs, ration care with eligibility rules and payment policies set not by beneficiaries but by Congress or state legislatures.

Consider, for instance, Medicare’s switch in hospital reimbursements from daily historic costs to a prospective payment system based on diagnosis. No longer could hospitals influence future reimbursements by running up higher current costs with outlays for the latest diagnostic tools. No longer could hospitals benefit from keeping patients extra days. With prospective payments, hospitals fare best by providing the minimum service necessary for the diagnosis in the fewest possible days.

A more recent change in Medicare reimbursement policies for doctors—which limits the fees they can charge, based on a resource based relative value scale that is keyed to physician time and costs—could induce some specialists to turn away elderly patients, even those who might be able to afford more than the basic plan.

Medicaid’s low reimbursement rates impose even stricter limits on the care available to the financially needy, with significant consequences for health.

Even private health insurance imposes constraints on its beneficiaries, said Custer. A wide variety of such plans is available, ranging from first dollar indemnity plans to free-standing health maintenance organizations (HMOs), each with different sets of incentives and restrictions dictated by a desire to control costs.

Choices here most often are made by employers, not potential patients, in response to the tax treatment of health insurance as an employee benefit and to insurance market and group pressures. “A company with one size plan, even three or four plans, can’t fit the needs of all its employees,” he said.

Income, occupation, and health status also can limit the private insurance that consumers can buy. Then, once a plan is purchased, decisions move further from the consumer: to insurers, employers, and managed care directors.

Physicians historically have been the primary decision makers—and rationers—of health care in this country, making choices for patients based on knowledge of the patient’s medical condition and available financial resources. In theory, the doctor acts as an agent, making decisions that are the same as those patients would make had they sufficient knowledge.

“Clearly, though, this is not happening,” Custer stated. The interests of physicians do not always align with the interests of patients. This rations the care that some patients receive. “People with similar illnesses receive different treatment and see different outcomes.”

Similarly, reimbursement changes for hospitals have limited their incentives to invest in new capital equipment and technologies, reduced their ability to subsidize uncompensated care, and restricted their medical staffs’ treatment plans. Again, the consequence is rationed health service.

Care also is rationed by geographic location, Custer said. Physician practice patterns vary significantly, even within the same state, influenced by local reimbursement practices, the relative market strength of public and private payers, even the political clout of a local medical society. Additionally, local competition among hospitals and with outpatient surgical centers and independent laboratories affect the availability and cost of various services.
Further limiting the health care choices available to consumers are the regulations of federal, state, and local governments, beyond those set for Medicare and Medicaid. State rules govern the number of physicians, limit the care that may be provided by chiropractors and free-standing clinics, and restrict the capital improvements that hospitals may undertake. The federal government regulates drugs and medical technology.

With it all, said Custer, “not only are there differences in the utilization of health care services between those with health insurance coverage and those without, there are significant differences between publicly insured individuals and privately insured individuals, Medicaid and Medicare recipients, group and individual coverage, and individuals with indemnity coverage and those enrolled in HMOs.”

And the decisions in this rationing “are not primarily being made by the consumers of these services,” he declared.

“The public policy issue is not whether we ration care, but can we find a more rational method of allocating resources?” Custer asked the forum.

The “most challenging issue,” as viewed by Mike Hash, a staffer on the House Energy and Commerce Subcommittee on Health and the Environment: Any national policy on health care financing will necessarily involve a “significant amount of income redistribution.” Yet there is little awareness of current costs. “In laying out issues for new costs, people don’t have a base,” he declared.

Allowed Karen Ignagni of the AFL-CIO: “It’s a difficult task retooling the third largest industry in America.”

But retool we must; on this one issue there was broad agreement at the forum.

Every other major industrial nation, continued Taylor, has “made the overt policy decision that its citizens should have universal access to basic health care services.” This decision has forced these countries to create a health care delivery system.

The United States, by contrast, has held that health care is a free market commodity, Taylor said. As a result, we have no national decision-making structure, only a “nonsystem” with piecemeal approaches, a badly frayed “safety net” for the poor and elderly, and tax incentives to encourage private insurance.

What U.S. policymakers have failed to recognize, stated Taylor, “is that by creating public charity hospitals, encouraging the expansion of medical schools and hospitals with public monies, and creating government-funded health insurance programs for the poor and elderly, they have tacitly decided that health care is a public right,” without creating a national system for delivering and financing this right.

“Can we afford not to put a system in place that has the ability to effectively manage cost, access, and quality?” he asked.

To Taylor, the answer is clear: Foreign countries that provide universal access to basic health care and have taken the position that society as a whole, through organized processes, should decide which services are to be universally offered, denied, or delayed are “both rational and humane.” We should look abroad for ideas, he said, “although our final solution will certainly be uniquely American.”

Worldwide, according to a Wyatt study, Health of Nations, government involvement in health care runs the gamut along a continuum from the United States’ market-maximized approach to the market-minimized system of the United Kingdom, with its government-financed and government-operated National Health Service.
Closer to Great Britain along this continuum is Canada, where hospitals and doctors are private but provinces are the principal payers. In the middle are such countries as Germany, Japan, and the Netherlands, each with a public/private mix of state-mandated social insurance funded through payroll and income taxes.

Masataka Kohda of the Pension Welfare Service Public Corporation in Japan said the Japanese government adopted universal health insurance in 1961 to bring protection to the nearly one-third of its population who were not covered by existing public or private plans.

For the previously uninsured—mostly retirees, the self-employed, those in very small companies, the elderly, and the poor—the government subsidizes 50 percent of the care.

Private and public workers generally split the insurance bill with their employers, although the government pays the benefit expenses, about 16 percent, for government-managed health insurance, which covers small- and medium-sized companies.

A central council sets fees for hospitals and clinics. A national group issues guidelines for clinical care. But, said Kohda, the providers are private. Most hospitals are nonprofit institutions run by doctors.

To make sure patients understand the costs, the government imposes a fixed copayment fee on patients that is approximately 10 percent, as well as deductibles per episode of illness.

Kohda said the public-private system has very effectively restrained health care outlays in Japan. In 1990, health care spending amounted to about 6 percent of Japan's gross domestic product, one-half of the U.S. spending rate.

But, acknowledged Kohda, Japan was able to achieve its success when it had high economic growth and a relatively young population. Both conditions have been changing in recent years.

Kohda, in response to a question from Paul Berger of Arnold & Porter, also acknowledged that Japan has not yet completed studies on the effectiveness of its health care.

Taylor said other industrialized countries also assure protection for all while imposing limits to restrain costs, as Japan has done with its treatment guidelines and fee schedules.

Britain, Canada, and Japan offer universal coverage, Taylor said. In Germany and the Netherlands, coverage is promised for only those below a certain income level; it is assumed the rest will buy their own insurance. In all five countries, people may buy more than the government-mandated basic protection if they so choose and can afford the added cost, although insurers in Canada are barred from covering services insured by the government. Citizens of all nations, however, share the American right to pay for more care than is covered by the public system.

But while the five governments require minimum coverage, Taylor said, quality control is left largely to health care professionals and the community. Patients in all five countries are free to shop for quality by choosing their own providers.

All five countries regulate fees for primary physicians. Germany, Japan, and the Netherlands set hospital per diems or fee schedules.

Britain, Canada, Germany, and Japan also set national or regional health care budgets. The Netherlands has budgets for hospitals and physician services.

Such spending curbs in all five countries have forced providers to set priorities for services and new technology. The Japanese, for instance, favor ambulatory care and high-technology diagnostic tests over surgical procedures. All five have public policies regulating reimbursements for technology and drugs.

In Britain and Canada, Taylor said, utilization controls have created significant queues for some nonemergency procedures. Patients in the Netherlands also must put up with protracted waits for some elective procedures. Australia and New Zealand, too, have lines for specialists and elective surgery. In Spain, some patients voice dissatisfaction with a national health system that imposes long delays, especially on service for the poor.
Germany and Japan, by contrast, “do not seem to have these problems,” Taylor said. Germany has been able to control technology through the budgeting process without creating long waiting lines. Japan has been able to control costs without imposing restraints on the often duplicative technology that competing hospitals offer.

Little wonder, observed Salisbury, that U.S. health care strategists looking abroad for models “have shifted their love affair from Canada to Germany or may next move to Japan.”

Taylor cautioned, however, that foreign experiences may not be replicable in the United States. “Other countries may have better health care statistics,” he said, “but this may be partly because we have more guns, demographic and ethnic diversity, and poverty.”

The United States, moreover, is starting out from a different base. We already have more high-technology equipment than most countries, so restraints on new purchases would be of less immediate avail. The United States, similarly, has more specialists oriented toward complex and expensive procedures, which would frustrate efforts to direct care to lower-cost primary care physicians.

Marilyn Field of the Institute of Medicine, taking a critical look at possible overseas role models, questioned the degree of choice open to patients in foreign national health systems. Germany and Japan may have several insurance programs, but individuals have little say about the plans they can join, she said. Wiener concurred that German employers have a number of insurance options but workers at each company are locked into whatever the employer picks.

William Link of Prudential Insurance Company of America asked if anyone in these foreign health systems ever challenged the quality of care delivered to them. “Does anyone sue?”

Stuart Butler of The Heritage Foundation responded that, in Britain at least, “there are some large suits.” Winning, though, is tougher.

In the United States, he explained, “we write everything down.” In Britain, “there are no clear guidelines. People don’t know what to complain about and where.”

More significantly, patients in Britain are presumed to assume a risk when they seek medical care. “There is no tort system as in the United States,” he said. To win a malpractice suit in Britain, “patients have to show culpable negligence. They have to show unreasonable risk.”

Change further complicates any comparison of national health systems: Many foreign countries are taking a fresh look at their care promises. “They went into universal health insurance with almost no limits or cost sharing in the 1940s to 1960s when it made sense,” said Taylor. “Now they are trying to back off from their definitions of that basic entitlement. Most countries have found it difficult to decide what not to cover, so they have pushed the decisions down to local levels. True rationing at the federal level requires a truly defined and managed health care delivery system nationally. Taylor further explained that in the United States we balance wants versus needs unsystematically, usually by the amount of money that is available. In other countries this balancing is done more systematically through policy.

“You need an effective national health policy to balance unlimited wants and limited resources,” Taylor reasoned.

New Zealand is rethinking its promise. The United Kingdom ponders how to introduce competition and more private choice. The Netherlands takes a broad look at its plan. Italy proposes to allow more private practice.

Even Germany, the putative model for the United States, is recasting its national health plan. Doctors, hospitals, dentists, and drug companies there will have to charge less; patients will have to chip in more.
The American public also is apprehensive about the current health care system in the United States.

"People are concerned and they are growing more concerned," said John Immerwahr of Villanova University and the Public Agenda Foundation. Many Americans fear that they or members of their families may soon lose health care coverage. During the recent presidential election, he said, health care ranked second only to the economy as the most important issue for voters.

"This is encouraging," commented Michael R. McGarvey of Alexander and Alexander Consulting Group. "It shows people are aware there is no real system. It sets the stage for professionals to bring some order."

But, said Immerwahr, the public's perception of health care issues differs sharply from the opinions advanced by policymakers and health care analysts.

To experts and leaders, the cost problem is the soaring national health care bill. To most Americans, however, the issue is their own out-of-pocket outlays, which they significantly overestimate, he said.

While experts and leaders have identified the nation's 36 million uninsured as largely the working poor and their dependents, the public believes that large numbers of the very poor and elderly are going without health care coverage, when, in fact, these are the very groups protected by government programs.

Most significant is the public's explanation for the surging rise in health care costs.

For the increases, experts most often cite fees-for-service, cost-plus reimbursements, overly aggressive purchases of technology, defensive medicine, an aging population, crime, and drug abuse.

The public, however, is more cynical. "All of our research shows that the public is convinced that there is a vast amount of greed, waste, fraud and other abuse in the health care system," Immerwahr stated. "In focus groups, virtually every respondent has a personal 'horror story' about a hospital bill with outrageous charges for household items like a bottle of Tylenol or a box of tissues or a hundred-dollar bill for a few minutes of a doctor's time. The public has a lack of trust in the leadership and most people are unwilling to make sacrifices because they are not convinced it is needed and that it will help others."

Immerwahr continued, "The public perceives the health care system as a complicated system full of black holes, and so they are not convinced that making cuts in some areas will help others."

Link suggested that, even if all the abuses were removed, the nation's health costs would likely still rise faster than general inflation because of such factors as our aging population and the increase in medical technologies.

Wiener noted that some of what the public perceives as outrageous charges (e.g., $10 aspirins) are the direct result of cross-subsidizing other health services. So long as we have large numbers of uninsured, this type of pricing is inevitable.

Immerwahr responded that the public saw only abuse. Older Americans think drug companies are the most greedy. Low-income and minority people point the finger at doctors. The middle class focuses on malpractice suits. "But everyone is convinced that health care is a vast sink hole," he said. "Given this perception, it is hardly surprising that people are unwilling to accept rationing."

Yet Americans are highly satisfied with the care they now receive from doctors and hospitals; 83 percent rate it either excellent or good, according to a recent survey conducted by EBRI in conjunction with The Gallup Organization.3 They are unwilling to sacrifice this care

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“just to put more money in the pocket of a doctor or an insurance company,” Immerwahr said.

Three out of four Americans reached in another EBRI/Gallup Survey agreed that “the cure to rising health care costs is not to put limits on what is available to average people, but to cut the waste, high profits, and fraud in medicine.”

If care has to be limited, most Americans would curtail expensive treatments that prolong life without improving the quality of life or are not likely to be successful, the EBRI/Gallup survey found. The majority rebuffed limits on services for the elderly or poor; expensive treatments paid by insurance or tax funds; expensive new technology that saves lives, and expensive treatments that do not prolong life but make sick people more comfortable.

**When asked, “Who is in the best position to limit health care?” 35 percent chose a local panel of medical professionals as one of their two choices from a list of 10; 35 percent picked family doctors; 29 percent selected a national panel of medical professionals. “Once confronted with rationing, people still felt it is important to involve physicians and do so on a local level,” Immerwahr explained.**

“People trust their own doctors,” McGarvey declared.

Elected officials came in a distant second. The survey, Immerwahr reported to the forum, found that 22 percent of the respondents favor a local panel of elected officials, and 20 percent prefer a national panel of elected officials. Barely 11 percent want hospitals to limit care; slightly more than the 9 percent prefer either insurers or employers.

Despite their rejection of rationing as an unnecessary sacrifice, only 11 percent of the respondents said “none of these” is in the best position to limit care. Six percent were listed as “don’t know, refused, any/all.”

**Sylvester Schieber of The Wyatt Company cautioned, however, that “we fall into a trap if we follow public opinion. There are gross inconsistencies in public attitudes about health care,” he said. “We have to step back and come to grips with issues. We need tort reform, but no one with grievances wants limits on their clients. We have too many heart centers, but many people want those kinds of capacities in their local hospitals. The list goes on and on.”**

Declared Schieber: “We didn’t go into World War II based on the public desire to go to war. Someone has to make the hard choices. Someone has to lead.”

Hash is more concerned about what the public has to say. “It helps to know what the public thinks,” he said. “We need to include initiatives that respond to concerns.”

Mike Miller of Rep. Sander Levin’s office swung back to the need for leadership. “People want change but there is no agreement beyond this,” he said. “Leadership has to put together a policy and sell it to the people, communicating the benefits and down sides, showing how it is better than what we have now.”

In the United States, several proposals for rationing and resource allocation are under review, among them global budgeting; an all-payer system; gatekeepers with fee schedules; and explicit rationing, as in Oregon’s plan. Some elements of each plan have been proposed as elements of the other plans.

Global Budgeting

**Ignagni presented the case for global budgeting. “A global budgeting system,” she said,**
“is the only cost containment alternative that would involve the type of systemwide restructuring necessary to achieve the results that the American people expect but with the checks and balances and opportunities for involvement that will ensure their support.”

Budgeting strategies could run the gamut from benign oversight to aggressive control: from a national watchdog agency to national spending targets that, in turn, could trigger spending caps based on a percentage of gross domestic product, specific dollar limits, or a percentage rise from the year before. A cap on percentage increase would be the most flexible and “most likely to work,” she said.

The cap could be imposed on core benefits or on managed care. “We can manage care but be wary of the hype,” she said. “Business and labor would like to believe it can work, but thus far that hasn’t been the case.” Even so, she asserted, “if managed care can achieve results, a cap is nothing to fear.” If managed care cannot restrain costs, a cap offers a standard against which performance can be measured, she said.

Global budgeting, Ignagni contended, would offer a predictable and effective strategy for containing costs; could be implemented with a blend of regulatory and market-based approaches; would force the United States to develop an overall health care policy, with broad public participation; would call for the development of a system for keeping tabs on volume, performance, and price; and would require a process for determining the efficacy of new technology and capital spending.

Ignagni also pressed for circumscribing the role that Congress would play in global budgeting or, “if there ever were compelling reasons,” for explicit rationing.

“The worst thing to do is micromanage the system on Capitol Hill,” she declared. Congress should set broad policy. However, she said, the power to develop, monitor, and conceivably implement the system should be vested by Congress in a broadly representative public-private independent commission. “Participants and providers are going to insist on a role,” she asserted. “Public acceptance is the key.”

Butler shared Ignagni’s disaffection for congressional management. “We have to get it out of Capitol Hill. People won’t stand for it,” he said, before quickly adding, “but they also won’t stand for an independent commission.”

Hash suggested Congress could “lay out a commitment, financing scheme, and a series of standards in the context of a budget.” But he, too, said Congress should not “write minute details.”

As for a commission? “It is not a silver bullet,” Hash said. “That would just transfer lobbying from Congress to the commission.”

At least, injected Ignagni, “an independent body would not have to run for reelection.”

“Public acceptance is the key,” she said. “To cut costs, we need public involvement and doctor self-policing.” People, she added, “have a better sense of the problem than ever before. They want predictability. This leads to global budgeting.”

Chris O’Flinn of Mobil Corporation said the business community concurs that global budgeting is “a good idea.” Managed care, he said, “has failed.”

Taylor, too, saw merit in the approach. To create a budget, he said, a country must have a national policy. Global budgeting in a competitive environment would lead to “a level playing field” and “more reasonable standards; it will help produce the private and public infrastructure that can manage both cost and quality.”

Butler, however, was unconvinced. “I can’t see how it will actually function,” he asserted. “Global budgeting won’t solve anything if it is just a wish, just a measuring tool. If it does mean something, it will have to be very complex with special cases. Doctors and consumers pose countervailing pressures.”

While supportive of global budgeting, Wiener was uncertain “how it would work in the U.S. system,
which is dominated by private insurance.” Moreover, if the object is to restrain cost increases, “how do you get from an 11 percent annual increase to a 5 percent increase? What do you give up?”

To Link, “whoever talks about a global budget creates a box but leaves it blank.” In his view, “we really need to define what we are talking about in order to have a meaningful discussion.”

An All-Payer System

Larry Atkins of Winthrop, Stimson, Putnam & Roberts stated that an all-payer system is one way to implement global budgeting. An all-payer approach gets to the heart of the issue by tackling provider revenue. In such a system, he said, every payer—be it private, managed care, Medicare, or Medicaid—would “pay a particular provider the same price for a particular type of service.”

Any number of mechanisms could establish the rates paid doctors, hospitals, and other health care providers. The rates for each service could be developed nationally or regionally by a public or quasi-public body, be imposed or negotiated, be uniform for all providers or vary from provider to provider, or be applied to fee-for-service or diagnostic-related reimbursements. Once established, however, the rates would have the force of law. “For any one provider all payers must pay the same rates,” he explained.

An all-payer system, he said, would end cost shifting and force the government to assume its full share for Medicaid and Medicare. This might expand the number of providers willing to handle Medicaid patients, he added.

Moreover, coordinated action by all payers would impose a discipline on total spending that no one payer could command. Providers would be forced to reduce costs rather than shift them. He said hospitals would be induced to reduce excess capacity, limit capital outlays, and allocate new technology properly.

What’s more, Atkins said, the approach could be implemented quickly, and “America’s experience with all-payer systems, although limited, has been largely successful.” He said 27 states at some period had forms of hospital rate setting, and they managed to hold their costs below other states.

For a time, four of the states included Medicare in their rate-setting mechanisms. However, three of them dropped Medicare from their plans when hospitals argued they could get better reimbursements under Medicare’s then-new diagnostic-related prospective payment system.

At present, only Maryland continues an all-payer system for hospitals that includes Medicare. And, said Atkins, Maryland’s experience has shown a drop in hospital costs per admission from 25 percent above the national average in 1976 to 10 percent below in 1991. Per capita hospital costs are 14 percent below the national average.

Atkins said Rochester, NY, has demonstrated the effectiveness of community negotiated rates. “The Rochester model, which evolved over 25 years, today combines community negotiation of hospital budgets and provider rates and regional health planning with community rating of insurance premiums and an emphasis on HMOs.” As a result, he said, health care costs in Rochester have risen at an annual rate nearly four percentage points below the national average. Costs per employee run two-thirds the national average. Rochester shows “you can get excess capacity out of the system.”

Atkins, issued some cautions, however. By generally focusing exclusively on hospitals, all-payer efforts in the past have managed to shift care out of hospitals into nonhospital settings, including doctors’ offices. “Any effort to control total expenditures must apply to all settings,” he said.

Doctors and hospitals “strive to maximize their returns just as any individual or enterprise does,” Dan Leach of Lutheran Medical Center acknowledged.

Atkins said Congress could set guidelines for an all-payer system. A national council could prepare targets. However, actual rates would be
negotiated by state or local councils representing payers such as insurers, employers, and consumers, and providers such as doctors and hospitals.

Mark Gibson of the Oregon State Senate President’s office saw need for dual authority. A commission would have to look after the technical and clinical components of health care rationing. Only Congress, however, is in a position to decide how much of the nation’s total resources should be allocated to health care needs.

Rosalyn Sterling-Scott of the Charles Drew University of Health and Science suggested that we “look beyond doctors and hospitals, to our capitalist system.” Suppliers of technology and drugs “should not do so at tremendous profit,” she declared.

Atkins said an all-payer system, which basically affects the unit price of a service, must also include some strategy for controlling the volume of service. Additionally, it must provide incentives for quality and efficiency. That, added Taylor, is exactly the problem with simple rate setting; it can reward inefficiency and lock in the current fee-for-service mindset. Pluralistic capitated or budgeted delivery systems that are free to reward efficiency and quality will build a better infrastructure for innovative solutions.

Gatekeepers

Cynthia Hosay of The Segal Company said gatekeepers and fee schedules would broaden the focus of our response to the health care crisis from simply controlling costs to assuring quality care that is both appropriate and in a proper setting.

Under a gatekeeper system, she explained, a primary care physician becomes a patient’s entry into the health care system each time care is required. Only when a gatekeeper finds that further service is necessary would a patient be allowed access to a specialist. “Patients would not have to try to diagnose themselves by deciding whether they should see a neurologist or an orthopedist for back pain,” she said. Self-referral would be prohibited.

Gatekeepers could enhance quality by assuring coordination of care, eliminating both duplication and gaps in service. Gatekeepers, too, could ease patient stress by helping consumers “navigate our complex and often intimidating health care delivery system,” she said. And gatekeepers could control costs because primary care physicians can frequently diagnose and treat conditions without referral to more expensive specialist care.

Hosay said the implementation of fee schedules based on relative values rather than usual charges, akin to what Medicare has done, could further “diminish rewards for high intensity specialty care” and switch emphasis “toward services that encourage prevention and continuity.”

Wiener concurred that gatekeepers work in Europe. But he noted we already have a lot of specialists here, to which Hosay responded, “We could have controls on specialists in medical schools.” That, in turn, prompted Leach to ask if medical schools were adequately training enough primary care physicians to act as gatekeepers. “We have a long way to go,” Hosay said. McGarvey added that some medical school deans want to keep family practice out of their schools.

But when Mary Jane England of the Washington Business Group on Health suggested that other health care professionals, beyond doctors, might serve as gatekeepers, Hosay demurred, at least for the start. “Let’s begin with doctors. Employers are comfortable with them,” Hosay said.

Hosay also resisted a suggestion from Miller that primary care physicians might be called “care coordinators” rather than “gatekeepers.” Hosay said the term “gatekeepers” clearly defined their role as the point of entry into the health care system.

In presenting her case for gatekeepers, Hosay...
noted that doctors long have argued that they alone, “rather than their patients or payers, should allocate resources, making pivotal decisions about the kind and quality of care required by their patients.” Doctors’ medical knowledge and their familiarity with each patient’s history, physicians have contended, “make them uniquely qualified” to determine the needs of their patients.

“Rather than submit to the scrutiny of outsiders, such as utilization review organizations, who make medical decisions based on statistics and create layers and layers of additional paperwork and bureaucratic morass, most physicians seem to prefer assuming management for their patients themselves,” she said.

Hosay said her position in favor of gatekeepers was based on the assumption that “there is merit” to the doctor’s traditional point of view.

“It is clearly essential that we develop means to allocate resources, but it does not follow that care must be rationed,” she averred. “The use of primary care gatekeepers can enhance quality and control costs.”

However, at other points in the forum a number of participants questioned whether doctor self-interest was improperly influencing the care decisions that physicians make for their patients.

As stated before, Custer saw doctor-patient interests often at odds. “It is clear that physicians alter their decision making in response to the financial incentives presented to them by their patients’ insurance plan.” Also, as he reported in EBRI Issue Brief no. 131, changes in Medicare reimbursement policies for hospitals have affected the number, length, and intensity of hospital admissions, all of which are controlled by admitting physicians. “The implication is that physicians respond to a variety of incentives in making medical decisions that determine the allocation of health care resources.”

Ignagni voiced a similar view. “We are moving to economic considerations, moving away from medical practice,” she said.

But what is medical practice: Is it science or art?

To Custer, medicine is being practiced as an art, as if “there is no one true way to provide treatment for a patient.”

To England, however, “medicine is not an art, it is a science. We can measure it. But the medical profession has avoided ways of measuring care and being held accountable.”

Link offered a hypothetical case of conflicting interests: an HMO that will not cover bone marrow transplants for treating certain types of leukemia. Does a physician at the HMO refrain from advising a patient that such treatment might be effective, lest that patient sue for care denied? Or does the doctor pass on the information and place all the blame on the HMO?

Suzanne Horn of Metropolitan Life Insurance Company deplored that doctors often “ignore the patient” in making health care decisions. “We must educate the patient to make informed decisions,” she said. By the same token, she added, doctors also would be shirking their responsibility if, in the bone marrow case, they simply shifted the blame to the HMO.

In Britain and Canada, where universal coverage dictates which treatments are available to all, the handling of such cases “seems to be more humane,” Butler said.

He explained that British and Canadian doctors are recognized as health care agents for both their patients and their national health systems. In the United States, by contrast, such constraints as the threat of malpractice suits leave doctors with fewer options. They are not free to make decisions for both consumers and the national interest. For that reason, he added, it would be impossible in the United States to have the decentralized physician-based rationing that works in Britain or Canada. “That is a fatal flaw.”

Patients in the United States, said England, can be educated to make health care decisions on their own behalf. The Planetree Model Hospital Project in California, for example, is founded on the belief that having access to information enables patients to become active participants in restoring and maintaining their health,
she noted. At Planetree, all patients have the opportunity to read their own charts and are provided information about diagnosis, medications, and treatment.

Sterling-Scott countered, however, that “informed consent is a fallacious issue; patients can’t learn enough in 20 minutes.” But, she added, physicians who spend that much time explaining treatment to patients show at least that they “have thought about it and care.”

Wiener raised another issue. “If we are going to explicitly decide what to cover and what not to cover and how much,” he asked, “who is going to get to make these decisions? If we just turn it over to the medical profession, then the values that will dominate those choices are those of white, middle-aged, upper-middle class men.”

The Oregon Plan

(Since Mark Gibson made a presentation about the Oregon Health Plan at the EBRI-ERF policy forum, the Clinton Administration approved the demonstration plan and the corresponding federal Medicaid waivers necessary to help implement the program. See “Explicit Rationing/ The Oregon Proposal” on p.57 and the text of the Oregon Plan on p.61 for more information.)

Oregon seeks to resolve such issues with a system fashioned by input from the public that offers universal health care with explicit rationing. Federal approval is required because the plan would modify Medicaid rules.

The proposal, said Gibson, “eliminates the implicit tools of health care rationing imposed by states, businesses, and the federal government today, and replaces them with an open, clearly defined, resource allocation process that combines considerations of clinical effectiveness, social value, and fiscal responsibility. Explicit rationing does not preclude the other systems we’ve discussed today—global budgeting, gatekeeping, and an all-payer system.”

Gibson said “virtually all Oregonians” would be assured access to health care under the program. Everyone under the poverty level would get “adequate basic coverage” through Medicaid. Employees would get at least the same coverage at work, “on a cost shared basis,” he said.

The state conducted extensive meetings, hearings, and surveys to determine what the public considered to be “adequate” care. With the input, a commission created a list of 709 conditions and related treatments—such as appendicitis-appendectomy—and ranked the pairs according to their benefits. An actuary then estimated how much each of the pairs would cost in a “managed, prepaid, capitated delivery system.”

These rankings and estimates next were submitted to the state legislature, which had to decide how much money the state could afford to spend without changing the order of the treatment pairs, eligibility standards, or reimbursement levels. The 1991 legislature approved $33 million of new revenue, which would fund condition/treatment pairs 1 through 587.

Wiener questioned whether the plan would work. Britain, he said, rations care by limiting the supply of services, such as the number of renal dialysis machines. There is no rule that says the elderly should not receive renal dialysis, but the shortage of machines forces doctors to resort to triage, giving preference to the nonelderly.

Oregon’s plan, said Wiener, presented an all-or-nothing decision that may not be sustainable. Gibson answered that Oregon’s proposal would allocate resources and not mandate medical practice. “Remember, the Oregon plan provides all services that are considered effective, life-saving measures.”

Wiener also questioned whether Americans would tolerate the explicit rationing of the Oregon plan, with its deliberate withholding of services. “Constraining supply,” he argues, “would be more politically tolerable.” To this Gibson responded: “Painting an accurate picture will build credibility. This is only a first step.” Gibson hoped ultimately for “definitive federal action.”
Certainly, leadership is essential. However, leaders cannot lead a nation where it is unwilling to go. This was the message punched home again in 1989, when retirees forced the repeal of the Medicare Catastrophic Coverage Act because they felt the government was unfairly charging them for benefits their former employers already provided.

And if answers are to be found, Americans would look to doctors, not their elected officials, even though health care experts have told them that the interests of physician and patient often conflict.

Obviously there are inconsistencies and incongruities in these public perceptions. Nonetheless, they rank among the realities of the health care debate.

Ignoring public opinion would be foolhardy. Equally perverse would be the hope that this public opinion could be changed swiftly.

And it should not be forgotten that the United States is rationing health care now, the question is can a more rational way be found?

The Clinton administration, in considering its health care options for the next four years, would do well to concentrate its immediate efforts on what the public would find doable, while dedicating its long-term strategy to winning public consensus for a much-needed broad-based reform.
Health Care Rationing: The Public’s Perspective

John Immerwahr,

senior research fellow, The Public Agenda Foundation and professor and department chair, Philosophy Department, Villanova University

It is commonly accepted by health care experts that health care services are being rationed today and that they will be rationed increasingly in the future. However, there is a wide gap between public and expert thinking on this issue. Most of the public does not now accept the necessity of rationing, and there are major obstacles in public thinking that must be addressed before people will struggle realistically with this issue. Nonetheless, once people get past these obstacles, they have some specific ideas about how rationing should work.

This discussion raises two questions:

• What does the public think of the concept of health care rationing in general?
• What principles does the public think should be used to ration health care, if it is to be rationed at all?

The answers to these questions are based primarily on research conducted by the Employee Benefit Research Institute (EBRI) and the Public Agenda Foundation.1

Rising Levels of Concern about Health Care

There is no question that health care has moved up on the public’s agenda of important issues. A recent Harris study found, for example, that voters name health care as the second most important issue (after the economy) in determining whom they will support in the presidential election.

The public’s concern about the future of health care also seems to be changing. The Public Agenda Foundation has been conducting focus groups to monitor public thinking on health care foundation for over two years. In the early groups, most people mentioned the cost of health care as their chief concern; the problem of many people without coverage was clearly of secondary importance. Recently, more and more respondents have shifted their concern toward the problem of coverage, and they frequently express a fear that they themselves or their family members will soon be among the uncovered.

Those who follow health care issues closely have observed this rising level of concern. Legislators have read recent survey results as evidence of a “rising tide” that will translate into support for health care reform. Our own research suggests that while these statistics do indicate considerable public anxiety, they do not mean that there is broad support for fundamental change in the health care system.

For most Americans, the crisis in health care has very little to do with health care itself. The problem is not that Americans do not like the health care they receive. The problem is that they fear they will not be able to afford it.

Example: Education provides a clear example of the difference between public concern that focuses

directly on an issue and public concern that focuses on affordability rather than substance. Surveys show that people are concerned about both K-12 education and about college. But their concerns are dramatically different. Public concerns about K-12 education mostly focus on education itself. People are troubled by what actually happens in the schools in terms of discipline, curriculum, drugs, and school prayer. They fear that children are not being well educated. Money is a secondary issue. Except for school superintendents, hardly any group is convinced that more money alone will solve the problems in K-12 education.

The public's attitude toward college education is quite different. By and large, people think that colleges and universities do a good job. Their concern is not with college education itself, but with whether they can afford to send their children there.

Thus, while survey results on K-12 education might be evidence of a rising tide of support for fundamental change, survey results about colleges do not suggest that the public wants college reform. People only want to be able to afford what is already available.

Public attitudes toward health care resemble attitudes on college education more than attitudes on K-12 education. Most Americans are very impressed with many aspects of the health care system. They are satisfied with the services they receive (although there is some slippage here), and they respect “high-tech” medicine. Their concern is purely economic. They are afraid that they will not be able to afford to participate in the health care system.

Harris found that nearly two-thirds of Americans (61 percent) now say that they worry that “health insurance will become so expensive that they will not be able to afford it.” When people say they are worried about health care, they are clearly not calling for a change in the health care system itself. What they are looking for is a way to keep what we already have but to somehow control the costs so that it is affordable.

The “Third Rail” Problem

When we look at the public’s concern about health care as a concern about affordability (as opposed to a concern about health care itself), the discussion about rationing takes on a different aspect.

First, there is little doubt about the public’s overall hostility to the rationing of health care services. A 1987 Harris survey found that more than 7 out of 10 Americans (71 percent) believe that “health insurance should pay for any treatment which will save lives even if it costs one million dollars to save a life.” This is in direct contrast to the attitudes of leadership groups; for example, only 23 percent of political leaders agreed with this statement.

Some observers, such as Daniel Callahan, have attributed this widespread public resistance to rationing to cultural factors such as an unwillingness to accept the necessity of death. These observers have called on Americans to rethink their values about basic issues such as the relationship of health to overall quality of life. No doubt there is substantial truth in this view.

However, it is also useful to look at attitudes toward rationing as a manifestation of general public attitudes toward economic cutbacks and sacrifices. Health care, after all, is not the only area where Americans resist accepting sacrifices and making hard choices. While the vast majority of economists agree that the federal deficit can only be reduced through a combination of increased taxes and cuts in middle class entitlements, mainstream politicians view this solution as political suicide. Proposals to cut spending in popular programs such as Social Security are often called the “third rail” of politics: “touch it and you die.” Public opinion analysts have also pointed out the paradox in the public’s mind: people say they oppose tax increases, and yet they want the government to spend more money on many items such as health care, poverty, prison construction, police, AIDS, and so on.
Table 1

<table>
<thead>
<tr>
<th>Which statement do you tend to agree with most:</th>
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<tbody>
<tr>
<td>Given the explosion in the cost of health care, sooner or later we are</td>
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<tr>
<td>going to have to accept limits on what health care is available to the</td>
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<tr>
<td>average person.</td>
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<tr>
<td>The cure to rising health care costs is not to put limits on what is</td>
</tr>
<tr>
<td>available to average people, but to cut the waste, high profits, and</td>
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<tr>
<td>fraud in medicine.</td>
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<td>Don't know/no answer</td>
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Seen in this light, people's difficulty accepting the need for health care rationing is not solely a manifestation of their views about the sanctity of life or the overall importance of health care. Health care is one more area where the public is unwilling to accept economic givebacks or sacrifices.

Why Is the Public Unwilling to Accept Sacrifices?

The public's unwillingness to discuss givebacks or tax increases is frequently cited by the experts as evidence that the public is ignorant, selfish, emotional, and shortsighted. Politicians are universally criticized for pandering to the public's most debased tendencies. But why is the public so reluctant to pay higher taxes or accept givebacks?

Survey research on health care suggests that the public's resistance to accepting sacrifices may be due more to mistrust of leadership than to selfishness and short-sightedness. Lack of trust in institutions is so widespread that people are convinced that sacrifices on their part will not solve the problem. They are convinced that their sacrifices will be eaten up by a system that is corrupt, wasteful, and greedy.

All of our research shows that the public is convinced that there is a vast amount of greed, waste, fraud, and other abuse in the health care system. In focus groups, virtually every respondent has a personal "horror story"—about a hospital bill with outrageous charges for household items like a bottle of Tylenol or a box of tissues or a hundred dollar bill for a few minutes of a doctor's time.

It is interesting to compare public perceptions of waste in health care to their perceptions about waste in the Pentagon. People have read newspaper stories about $1,200 coffee makers, but they have seen hospital bills with $5.00 for a bag of ice or a bandaid. The only area of disagreement among the public is which villain is the most greedy: older people point the finger at drug companies; low-income and minorities single out doctors; the middle class focuses on malpractice costs. But everyone is convinced that health care is a vast sink hole, where billions of dollars disappear every year.

Given this perception, it is hardly surprising that people are unwilling to accept rationing. Why, they ask, should people be asked to give up health care that might save or improve their lives, just to put more money in the pocket of a doctor or an insurance company? A recent survey by EBRI and the Gallup Organization, Inc. asked a question that brings this out clearly. By overwhelming margins of nearly four to one (77 percent to 20 percent) the public insisted that the way to cut health care costs was not to ration health care but to cut waste, high profits, and fraud in medicine (table 1).

This finding is echoed repeatedly in focus groups. Because people believe that tremendous amounts of money are being wasted in health care, they are not ready to accept cutbacks such as rationing. One respondent was asked about whether it makes sense to spend up to half a million dollars to help a premature infant who has only a small chance of a healthy life. His answer was typical:

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

Selfishness or Lack of Trust?

Research by Public Agenda and EBRI suggests that the reason why the public will not accept givebacks or sacrifices is often misunderstood by leadership. The

problem is not that people are too short-sighted and selfish to make any changes. The problem is that people are not convinced that sacrifice is really necessary, and they do not trust leaders to implement the sacrifices fairly.

Most people approach these questions with a common sense practical view that asks “why should I let you cut back services when you are wasting and stealing the money you already have?” Our hypothesis is that people would be willing to accept rationing if they trusted the health care system enough to be convinced that less health care in one place would mean more health care resources somewhere else—not higher profits for health care providers.

Although people resist rationing health care given the high degree of waste and greed they perceive in the system, they seem to be quite ready to discuss what principles should be used in rationing if it becomes necessary. Their willingness to grapple with how rationing might be done if it is needed suggests that the core of the resistance is people’s lack of conviction about the need rather than a widespread repugnance to the idea of rationing itself.

The EBRI/Gallup study raised a series of questions that started with the premise that rationing is necessary and asked how it should be done. The answers are quite revealing.

Who Should Ration?

One question asked the public which groups are qualified to set limits on the amount of health care that is available. The survey presented a number of different groups and asked which ones would be in the best position to set limits. It is especially interesting that only a small minority (11 percent) answered the question by saying “none of the above.” Thus, although people are not convinced that rationing is necessary, they are able to move beyond that position to discuss how rationing should be done.

Not surprisingly, there was considerable resistance to letting hospitals, insurers, or employers make the decisions. On the other hand, there was a quite a bit of support for turning this question over to local medical professionals or family doctors. Seven out of ten (70 percent) named one of these two groups as an acceptable limit setter (table 2).

In other words, the public thinks that local professionals are preferable to national groups and that medical professionals are better than politicians, insurers, or hospitals.

In focus groups, people often resist the idea of global criteria for rationing. They seem to believe that each case is different and that rationing will be most fair if individual differences can be taken into account. The insistence on local medical professionals seems to be one way for the public to insure this.

How Should Rationing Be Done?

In thinking about rationing itself, people have an initial preference for rationing based on the procedure involved rather than rationing based on the cost of the procedure or characteristics of the patient. As the chart shows, people categorically resist the idea of limiting procedures merely based on who would receive them. There is little support for limiting health care services for people because they are elderly or poor. Nor is there much support for limiting services solely because they are expensive or must be paid for out of tax money.
Once people are convinced that rationing is necessary, they support limiting procedures that will extend life without enhancing its quality and procedures that have a low rate of success. The public is divided on whether it is appropriate to spend a lot of money solely to make a sick person more comfortable (table 3).

Once again, these findings are echoed in focus groups. Many people relate experiences with a dying relative who, it seemed to them, was kept alive at great expense long past the point where there was any benefit—either for the patient or for the family. Indeed, many respondents said that the medical establishment keeps people alive either to make more money on them or to reduce the risk of 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.”

There seem to be several principles guiding the public’s thinking about rationing in health care.

- Rationing will never be acceptable until people are convinced that waste has been reduced and that the savings will actually have a public benefit rather than enriching health care providers.
- Local medical professionals, who can take into account individual differences, are in the best position to make rationing decisions.
- Rationing should not be based on external factors such as a patient’s age or financial status or the cost of the procedure.
- Rationing should be based on what the procedure can be expected to accomplish.

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<thead>
<tr>
<th>Table 3</th>
<th>Acceptable</th>
<th>Unacceptable</th>
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<tr>
<td>Unacceptable limitations:</td>
<td></td>
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<tr>
<td>Services for the elderly</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>Expensive treatments for people over 75</td>
<td>30%</td>
<td>69%</td>
</tr>
<tr>
<td>Services for low-income people</td>
<td>31%</td>
<td>66%</td>
</tr>
<tr>
<td>Insurance payments for expensive treatments</td>
<td>31%</td>
<td>61%</td>
</tr>
<tr>
<td>Expensive treatments for people with no health insurance (paid out of tax money)</td>
<td>39%</td>
<td>59%</td>
</tr>
<tr>
<td>Introduction of expensive technology which saves lives</td>
<td>39%</td>
<td>57%</td>
</tr>
<tr>
<td>Expensive treatments which make sick people more comfortable but which don’t prolong life</td>
<td>46%</td>
<td>52%</td>
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<tr>
<td>Acceptable Limitations:</td>
<td></td>
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<tr>
<td>Expensive treatments that prolong life but don’t improve quality of life</td>
<td>64%</td>
<td>34%</td>
</tr>
<tr>
<td>Expensive treatments that are not likely to be successful</td>
<td>72%</td>
<td>27%</td>
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The United States allocates more of its resources to health care than any other country in the world. U.S. health care expenditures are expected to be $812 billion—14 percent of Gross Domestic Product (GDP)—in 1992. In 1990, the United States spent $2,566 per person on health care—more than double the Organization for Economic Cooperation and Development average. The United States outspent Canada by 45 percent, France by 67 percent, Germany by 73 percent, Japan by 119 percent, and the United Kingdom by 164 percent. And despite the fact that U.S. employers and government programs have instituted prospective payment, raised deductibles and coinsurance, developed and encouraged enrollment in managed care organizations, health care costs continue to rise in the United States at about twice the rate of other developed countries.

Despite this level of spending, the United States falls short of its major economic competitors in many of the statistical measurements of population health. The areas where the United States has excelled are principally those fueled by our inflated spending on health care: medical technology, hi-tech therapies, and for-profit medical provider systems. Unfortunately, with an estimated 36 million people uninsured and an equal number reportedly underinsured, the population as a whole has not received the benefit of this success. In fact, the focus by our leading health care institutions and the media on the success of unusual, hi-tech, and expensive therapies serves to underscore the inequities in our current system, where many have limited access to these technologies.

Despite the appetite in the United States for health care spending, we also fall behind other countries in many areas of primary and preventive care. A large percentage of our population (including one-half of those with indemnity insurance) lacks coverage for preventive services despite the fact that these services have a much greater impact on population health than more expensive hi-tech therapies.

This paper explores how health care resources are allocated or rationed in several other industrialized countries around the world.

Economists call health care allocation decisions rationing, a term that has negative connotations among U.S. health care providers. As used by economists, however, rationing simply means the implicit or explicit way that health care resource allocation decisions are made. Judged by that definition, the United States rations health care at least as much as other countries. For example, it is rationing when a patient in the United States decides to delay surgery because of high copayments, as is the same decision made in Australia or New Zealand because the waiting queue in the public system is too long. Likewise, the unavailability of a liver transplant in the United States due to lack of coverage is as much a rationing process as is the same unavailability in the United Kingdom due to tight criteria for transplant candidate qualification.

It is curious that there should be such a strong aversion in the United States to the concept of rationing, because almost anyone will admit privately that we de facto ration care. It may be that the resistance to the term comes from the fear of government or society making rationing decisions, as opposed to the individual. That is, it might be acceptable for an individual to freely

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1 Susan Sorensen with The Wyatt Company assisted in writing this paper.

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decide to forego treatment because of his/her financial priorities; but it might not be acceptable for government to remove that choice by deciding that treatment will not be available to that individual. This tendency to think of government health policy as rationing but personal spending decisions and employer benefit plan policy as free choice is somewhat peculiar to the United States. At a minimum, this is an error in thinking. It fails both to acknowledge that we ration care in the United States and to recognize that citizens of other countries can almost always buy supplemental insurance or spend their own money for those health services not guaranteed by national health policy. At its worst, the antirationing rhetoric in the United States serves as an emotional red flag that impedes reasonable discussion of national health care priorities and budgets.

To compare the way resources are allocated in the United States and other countries requires an understanding of the context in which allocation decisions are made. All the other countries in this analysis have made the overt policy decision that their citizens should have universal access to basic health care services. Having made that decision, they then established health care delivery systems through which to deliver those services. As further needs were realized and technology developed, these countries had to decide what would and would not be included as universally available basic health care services. They also had to make decisions about how they would capitalize the development of hospitals, outpatient clinics, and other necessary physical resources, as well as how they would develop, educate, and pay for needed medical personnel. In short, the decision to provide universal access to basic health care forced these countries to create a health care delivery system.

It is difficult to compare the United States with other industrialized countries because health care in the United States is not delivered by “a system” and, in general, allocation decisions are not made at the national level. Historically, the government’s responsibility has been limited to public health, leaving private citizens responsible for personal health care. In the 1800s, public health largely focused on environmental factors such as disasters and water and food safety; later it expanded to include things like major immunization programs, professional licensure, and product safety. Personal health care focused on such personal choice items as medical supplies, physician care, surgery, and hospitalization. These personal health care items were considered part of the free market economy, where some could afford better care than others. For example, in the late 1800s the indulgence of having a nurse and doctor bedside in your home was just another of the many luxuries that came from being a successful capitalist.

The democratic and somewhat egalitarian foundations of American society could support this division between public health and personal health care for a number of reasons. First, in America, everyone theoretically had an equal opportunity to be successful and enjoy the benefits of that success. Second, the role of government was generally limited to national issues such as defense, trade, and the establishment of broad policy and legal frameworks. Government’s role was not generally seen as including the provision of individual social services. And finally, the perception of inequities in health care was somewhat limited by charity care, the absence of expensive lifesaving technologies, and a lack of comparative standards by which care could be judged. This approach to public health versus personal health care was common to most industrialized countries in the 1800s. Germany stood out as an exception among the industrialized nations in the late 1800s by adopting a policy that established fairly broad health care access for its citizens.

But health care has evolved dramatically since
the 1800s. Personal health care has become so expensive, technical, professionally dominated, and uniquely valuable in preserving life that it can no longer be considered a personal option or luxury. Between the late 1800s and early to mid-1900s, one country after another decided it could no longer tolerate the inequities, lost labor productivity, and inefficiencies that developed when health care is treated as an optional free market commodity.

It was during this period that the United States took a clearly divergent turn compared with the rest of the industrialized world. Instead of establishing a system to assure universal access to basic health care, the nation tried to hold on to the traditional view of health as a free market commodity.

By the 1960s, universal health care was the rule rather than the exception in the industrialized world. The United States was unique in its avoidance of a universal coverage approach. It tried, instead, to satisfy our egalitarian values through a series of safety net programs for the poor and elderly who are not well served by the free market model. It also encouraged the growth of private insurance through tax incentives and other means.

However, U.S. policymakers failed to recognize that by creating public charity hospitals, encouraging the expansion of medical schools and hospitals with public monies, and creating government-funded health insurance programs for the poor and elderly, they had tacitly decided that health care is a public right. They put government in the role of insurer of last resort. By failing to acknowledge this implicit change in policy, they also failed to take the appropriate leadership in systematically modifying the health care delivery system to implement this new reality.

By making publicly provided health care an implicit right, policymakers created a sense of public entitlement to personal health care services. This change increased both the demand and expectation for care while decreasing the need for individuals to plan for health care costs. It also allowed communities and health care professionals to remove public service and charity care from their list of social responsibilities, assigning them instead to government. Furthermore, the process of slowly backing into government’s current role through a series of separate programs aimed at different underserved segments of the population ended up splintering the responsibility for government health programs among various federal, state, and local government agencies with little overall coordination.

The U.S. health care system is termed pluralistic and market driven. It is often viewed as predominately a free market system of privately provided, employer-financed health care. However, the truth is that government directly or indirectly finances a larger percentage of health care costs than do employers.

Equally important, individual citizens finance a larger percentage of premium and direct out-of-pocket health costs than either employers or government. While larger employers and government agencies are now taking steps to limit their health care costs, many of these steps result in cost shifts to other payers. No agency is coordinating efforts to limit individual citizens’ costs. In short, the United States has allowed a nonsystem to evolve with no structure that can make overall national rationing or resource allocation decisions. It is ironic that many in the United States fear the concept of rationing national resources in health care, yet it is just such rationing that will allow us to guarantee basic health services to all. This discussion reviews how selected other countries have structured their decision-making processes. Hopefully, the fact that other countries have managed to limit the growth of health costs will reduce the fear of trying in the United States. What is clear to this author, however, is that we will not be able to implement systemwide resource allocation decisions in the United States until we better define our national goals, and the health care delivery system will be used to reach these goals.
Health care systems differ significantly from country to country. In each country there are myriad ways that health care decisions are made. Some of these decisions are strongly influenced by governmental policy; others are more strongly influenced by personal preference, the availability of insurance coverage, or the ability to pay out-of-pocket charges. To allow a more systematic comparison of these different systems, the Employee Benefit Research Institute Education and Research Fund (EBRI/ERF) policy forum divided methods of rationing into the following six categories:

- How is technology introduced and disseminated?
- What are the restrictions on choice of treatment and procedures?
- What are the restrictions on sites of care?
- What are the restrictions on choice of provider?
- What are the restrictions on timing of care?
- What are the benefits and consequences for coverage, cost, and quality?

The following sections describe selected international experiences for each of these categories.

Introduction and Dissemination of Technology

There is widespread agreement among health care experts that U.S. citizens have greater access to many high technology services than do the residents of most other countries. Joshua M. Wiener writes:

The United States has twice the rate per million persons receiving treatment for end-stage renal disease that Great Britain has. The United States has more than twice as many open heart surgical units per million persons as Canada and nearly five times as many as West Germany. Similarly, the United States has four times as many magnetic resonance imageries per million persons as West Germany and seven times as many as Canada. This variation is due partly to a lack of money for equipment and partly to a more skeptical view of technology on the part of physicians in other countries (Weiner, et al., 1992).

Wiener adds that, although the extent to which services are rationed in other countries is debatable, there is “undoubtedly more rationing of high-technology services than in the United States, and the United Kingdom represents an extreme that would be politically intolerable in this country.”

Victor Fuchs says that most countries with national health insurance rely heavily on “upstream resource allocation” (Fuchs, 1991). According to him, “the key to this is control over capital investment in facilities and equipment, specialty mix of physicians, and the development and diffusion of high-cost new technologies. Such control usually results in less excess capacity, in both physical and human capital.” Fuchs points out that in Canada, scarce high-tech equipment is used all the time in the few locations where it is located. In the United States, however, the proliferation of such equipment results in considerable idle time.

“There are more physicians per capita in Canada than in the United States,” writes Fuchs, “but fewer physicians there specialize in complex surgical and diagnostic procedures. As a result, the average Canadian specialist has a full workload, while his or her American counterpart does not.” Fuchs adds that, although the controls on high-tech services cause Canadians and Europeans delays or inconveniences, there is limited evidence that shows a significant effect on the population’s health.

Fuchs states that, although the United States is much more medically technologically advanced than other countries, it still has to catch up with other countries in areas such as efficiency (control the high cost of health care) and distributional equity (provide universal insurance).
Dale Rublee looked at the availability of six technologies in the United States, Canada, and Germany: open-heart surgery, cardiac catheterization, organ transplantation, radiation therapy, extra-corporeal shock wave lithotripsy, and magnetic resonance imaging (MRI) (Rublee, 1989). What he discovered came as little surprise: there is a greater proliferation of some major technologies in the United States relative to Canada and Germany. According to Rublee, “American physicians, with a universe of modern technology at their fingertips, are the envy of the world’s physicians. German and Canadian physicians, too, are well-equipped technologically, but do not, on the basis of the data, have as much major technology with which to work as Americans do.” Rublee goes on to say that:

Given the differing approaches to constraining technological adoption, it is not surprising that there are significant differences between countries in the extent of technological availability. This is particularly the case in Canada, where some major technologies, for example, MRI, are prohibited outside of hospitals. However, it is important to avoid possible misinterpretations. The differences can be interpreted to suggest overprovision in the United States rather than underprovision in Canada or Germany. Indeed, all levels could be optimal for the countries concerned, given different social values for technology in each of the countries concerned.

In Japan, having the most advanced medical technology ensures that a hospital will be able to continually attract new patients, which is important to physicians because the majority of Japanese hospitals are private, for-profit institutions run by doctors who usually have no background in hospital administration (Levin, Wolfson, and Akiyama, 1987). There are currently no laws that require a review process to determine whether investment in a particular technology is needed.

According to Theodore R. Marmor, the Japanese fee schedule rewards ambulatory care and diagnostic procedures more than surgery (Marmor, 1992). (In fact, Marmor says, “there is something akin to a Japanese aversion to surgery—with rates a quarter of ours, according to recent estimates.”) There is, however, a passion for diagnostic tests in Japan:

Japan has more advanced diagnostic tools (like CT scanners) than almost any other country. With so much of the diagnostic equipment owned by physicians, its use is an important source of medical income. Patients no doubt get more tests than they need, and domestic manufacturers understandably concentrate on producing diagnostic equipment. The result is that important innovations requiring surgery—like cardiac pacemakers—are not produced locally and are much more expensive in Japan than elsewhere. Japan has one of the highest kidney dialysis rates in the world, yet one of the lowest rates for organ transplants in general and kidney transplants in particular.

Although many Westerners think Japan’s health care system is a good example of universal coverage at a reasonable price, some critics disagree. For example, David Gross in a review of Health Care in Japan (Powell and Anesaki, 1990), points out that “One lesson the Japanese experience teaches us is that a disjointed delivery system, without adequate expenditure controls, will lead to a proliferation of expensive technological equipment, uncontrolled hospital growth, duplication of services, and increased volume in the presence of a payment system that encourages inefficient and excessive delivery of care.”

A recent National Public Radio report on the Dutch health care system said that, even when high-tech equipment is purchased in the Netherlands, the number of machines is limited. As a result, patients can wait for some tests and procedures such as CT scans and MRIs.

In conclusion, most health systems around the world work within budgetary constraints that force an early review of technology options, priorities, and relative cost effectiveness. For example, Canada, the Netherlands, Germany, Australia, and the United Kingdom use budgetary control in this way. Many governments, including those listed above, are also...
actively involved in technology and drug approval and in controlling the price and/or distribution of that technology. For example, New Zealand negotiates with pharmaceutical companies regarding whether a drug will be placed on the country’s formulary and the price at which the government will subsidize consumer purchasing. In general, New Zealand will not pay more for brand name drugs than for generic or therapeutic equivalent drugs. If a more expensive drug is allowed on the formulary and individuals choose to use it, they pay the difference between the drug's cost and the government's subsidy.

In most countries, expensive technologies are concentrated in hospital settings that are subject to global hospital budgets. This common practice puts technology purchasing decisions in the hands of local hospital boards that can evaluate the medical and community needs against the proven cost effectiveness of each new expensive technology. These hospital boards, like their national health board counterparts that recommend overall policy, often include providers, consumers, employers, and government representatives. This budgeting mechanism not only forces single facilities to carefully prioritize what technology is worth buying, it also encourages sharing of expensive technologies among facilities. The effect of hospital budgets on controlling technology is often reinforced by restrictions on public payment for expensive technologies in the private ambulatory setting. Regardless of the way technology is controlled, it is important to note that is possible to control technology expansion without creating long waiting lists (e.g., Germany). It is also possible to control overall health costs while placing little restriction on technology expansion (e.g., Japan).

Restrictions on Choice of Treatment and Procedures

Perhaps the most frequently cited examples of rationing health care treatment are found in the United Kingdom’s health system. The Painful Prescription, a controversial study of the availability of various medical procedures in the United Kingdom, compared the rate of hemodialysis (among other procedures) in the United States and the United Kingdom, arguing that “in imposing...[expenditure] limits, the British have encountered problems and made choices that the United States will face if it should undertake to sharply limit medical expenditures” (Aaron and Schwartz, 1984).

The study revealed that the overall rate of kidney dialysis treatment in the United Kingdom was approximately one-third that of other Western European countries and the United States. The age of the patient was seen to be a limiting factor, as dialysis rates for patients under age 45 were equal to those in the United States and Western Europe, but rates declined as the patients’ age increased. Kidney dialysis treatment for patients aged 65, for example, was performed at a rate approximately one-tenth that of other nations. While the United Kingdom does not have a formal, explicit age limit regarding dialysis treatment, it is clear that certain “policy decisions are implicitly made based on budget allocations” (Potter and Porter, 1989).

Because the United Kingdom’s central government sets budgets every year and then allocates amounts to the regional and district health authorities, the “British government essentially decides how much health care the British people should consume every year” (Willets, 1989). Health care financing levels are set according to the population’s estimated health care needs; “resources are provided prospectively with little if any adjustment for, or knowledge of, the actual level of activity undertaken” (Birch, 1988). For example, former Prime Minister Thatcher set limits on public sector spending for health; the target rate of real growth was to be held under 1 percent per year for the period 1979-1989 (Blendon and Donelan, 1989), but spending levels did surpass that target.

Such budgetary limits have collided head-on with a growing demand for health services by the population. The British health care system faces the same pressures as the U.S. system, including an aging
population, the high cost of advanced technology, and the spread of serious diseases such as AIDS and cancer. The "widening gulf" between available resources and demand for care "has made more explicit the existence of rationing: deciding who will die and who will live and in what degree of pain and discomfort, and the need to have explicit criteria for making such choices" (Maynard, 1990).

It is unfortunate that the majority of U.S. press coverage on the effects of economic rationing focuses on the United Kingdom. Rationing in most advanced countries is much less visible. In Australia, New Zealand, or Canada, its most publicized effect is waiting lists for elective surgery or specialist visits. Emergency cases are not subjected to these waits and, in most countries, there are ways to get around these waiting lists if you can pay for the service. That is, everyone has a right to a basic level of needed care, but those who can pay more may have increased access to the convenience of faster service and private care. It is also important to note that most other countries have a strong primary care orientation to care. Specialists are a much smaller percentage of providers and, in most cases, work on salary in a hospital setting. What may statistically look like lower access to high technology treatment and equipment may simply be another measure of that primary focus. Before we judge that to be inappropriate, we need to see if outcomes or satisfaction actually suffers. There are few studies on outcome, and populationwide health statistics, which generally favor other systems, are not specific enough to interpret in relation to any restrictions on needed treatment or access to new technology. Satisfaction levels with our health system are consistently lower than those reported in other countries, although again these studies are not highly specific.

It has been argued that U.S. analysts focus on rationing in the United Kingdom to mask the deficiencies in the U.S. health care system, particularly the existence of approximately 36 million people who lack insurance—or the existence, in other words, of rationing by ability to pay. It appears that rationing is in the eyes of the beholder: "To the British, the U.S. insurance situation, where insurance benefits limit access to care, would be considered rationing" (Potter and Porter, 1989). Indeed, one U.S. analyst questions whether "marketplace rationing has suited us as a nation because thus far it has tended to affect mostly those with the least means of fighting back." Rationing by price tends to be more hidden: "The multiplicity of players diffuses the accountability for, and the benefits of, their decisions" (Kosterlitz, 1989).

Restrictions on Sites of Care

In 1991, the Harvard School of Public Health and Cuanter, a Madrid survey organization, conducted a nationwide survey to measure the level of Spaniards' satisfaction with the Spanish health care system (Blendon et al., 1991). The authors indicate that waiting time for hospital admission in Spain is linked to patients' income level:

Twenty percent of upper-income Spaniards, versus 46 percent of lower-income Spaniards, report they had to wait for admission to a hospital. When placed on a waiting list, upper-income individuals waited an average of ten days for admission, compared with 39 days on average for lower-income persons. Similarly, there is little difference in the proportion of Spaniards, by income, who wait for surgery. When placed on a surgical waiting list, upper-income Spaniards stayed on the list an average of 124 days, compared with 325 days' wait for lower-income Spaniards.

An analysis of the Australian health care system indicates that reductions in federal funding in Australia have caused Australian hospitals to "rationalize the use of expensive services such as neonatal intensive care beds through area-wide coordination. Such expenditures require the approval of state health authorities, as is true of all capital funding for the installation of major new medical technologies, construction of new hospitals,
and major renovations” (Altman and Jackson, 1991). Under Medicare, Australia’s public health care program, patients receive free care in public hospitals, community centers, and from private physicians who accept assignment of benefits for nonhospital outpatient care. Australian citizens also have the option of purchasing supplemental health insurance, which entitles them to care in private hospitals where they can choose their physician. Thus, for both Australia and Spain, the waiting lines for public services may serve to push people with the means into private sites of care. Those without the means are restricted to public sites of care.

However, Australian state governments do regulate licenses for new private hospital beds, which gives state health authorities a certain amount of control over the location and supply of new private beds. Despite this control over private beds, it has not gone unnoticed that, while beds in private Australian hospitals have increased by 6.4 percent in the past four years, beds in public hospitals have declined by almost 11 percent. And this shift toward private care means that Medicare patients often have longer waiting times than those citizens with supplemental insurance (Altman and Jackson, 1991).

In considering restrictions on sites of care, it is again important to note that many countries concentrate their specialty physicians and high-tech services in the hospital setting, and highly specialized services may be centralized in a few facilities. Access to these providers under the public system often requires a referral from a primary physician. This referral requirement and resource distribution arrangement means that there are only selected sites where one can get certain services. However, there are generally no limits on which primary doctor, hospital, or specialist a patient chooses.

Restrictions on Choice of Provider

Most Australian physicians participate in Medicare, and Medicare patients who need outpatient specialist care and inpatient physician services are required to get that treatment from a salaried physician or one assigned by the hospital. Medicare patients do not qualify for the maximum reimbursement fees of a specialist in private practice unless they get a documented referral from a general practitioner. France is similar to a number of other countries in that it has specific fee schedules and supplements for ambulatory physician visits. Health care providers may choose to accept that supplement as payment in full (participating physicians), or they may balance bill the patient. This practice, much as with Medicare in the United States during the 1980s, also means that individuals’ ability to pay will influence which provider they can afford to see.

When looking at the restrictions placed on Japanese citizens regarding their choice of providers, it is important to note that, because Japanese law requires the medical directors of private hospitals to be physicians and all private hospitals to be owned by physicians, the owner-physicians have no interest in referring patients to their competitors or in allowing physicians who are not regular employees to have attending physician privileges in their hospitals. And as physicians compete for patients, there tends to be duplication of services, so that a hospital or clinic does not risk losing a patient to a competitor.

In the United Kingdom, each citizen enrolls with a general practitioner (GP). The GPs are the patient’s first point of contact with the system and determine when a patient will see a specialist. GPs actually play several roles, as they serve as “the patient’s gatekeepers in that they determine who is referred where and for what” (Day and Klein, 1989). Should the GP determine that a patient needs to see a specialist (consultant), the GP describes the patient’s condition in writing, specifies whether it is urgent or not, and requests that the specialist see the patient (Potter and Porter, 1989). This primary care referral requirement is seen in New Zealand as well, although individuals with supplemental insurance or cash can circumvent the requirement and see a private specialist directly. Again, the restrictions on sites of care and providers generally relate more to
the practical impacts of the government’s planned distribution of resources than to any government policy designed to ration care or restrict access. However, health maintenance organizations and other popular managed care arrangements in the United States restrict both provider and site of care choice more than the national plans discussed in this paper.

Restrictions on Timing of Care

A couple of years ago, when U.S. health care policymakers were looking to Canada as a potential guide for reforming the U.S. health care system, opponents of the Canadian plan were quick to point out that the Canadian health care system suffered from access problems and waiting lists for certain kinds of care in some parts of the country. This complaint was somewhat new because Canada’s system of universal comprehensive health insurance was created during a period of economic prosperity; rationing of care was rarely, if ever, an issue in the 1970s. Yet, as escalating costs begin to erode government’s ability to be all things to all people, resource allocation issues have been pushed to the forefront of health care policy and planning decisions.

Delays for certain medical procedures are not uncommon in Canada. An article in Macleans magazine described long waiting periods for coronary surgery; an estimated 1,000 people were facing waiting periods of up to a year for coronary bypass operations at three Toronto hospitals in 1989 (Barbar, 1989). In Toronto, 3.5 million people share two magnetic resonance imageries. In Montreal there are 21 CT scanners to service a population of more than 2 million, and in one Canadian province there is only one CT scanner for one-half million people. A patient can only have a CT scan on referral by a specialist, at which point the waiting time begins, often lasting over two months. Even such routine procedures as pap smears and mammograms can now involve waiting times of as long as several months. These waiting times, according the article, are “only one highly visible symptom of an underlying crisis that is undermining Canada’s health care system.”

A 1990 Health Insurance Association of America Research Bulletin had the following to say about the amount of time Canadian citizens have to spend waiting for health care:

The problem of waiting lists is real enough in Canada that at least two provincial health plans have felt it necessary to permit patients to seek care in the United States for certain conditions....To reduce a waiting list of 700 patients needing cardiac surgery, the British Columbia Health Association has contracted with two Seattle hospitals for up to 50 coronary bypass surgeries each over the next several months (until a new cardiac service opens in Vancouver) and may contract with two more Seattle hospitals for another 100 surgeries (Health Insurance Association of America, 1990).

Surprisingly, only 130 patients took advantage of the Seattle facility, even though travel and surgery expenses were paid by the government (Peterson, 1991).

Canada is not the only country that has waiting lists for certain medical procedures. In the United Kingdom, tight budgetary constraints have also led to waiting lists for particular types of nonemergency surgery. Waiting lists have been a persistent feature of the national health service since its inception, as it was created in an environment of postwar rationing of all goods and services. Yet public willingness to wait for certain surgical procedures has steadily declined (Willetts, 1989) as the “democracy of the till [became] more attractive than the equity of the queue” (Day and Klein, 1989). A chart in the November 19, 1988 issue of The Economist shows that there were 650,000 to 700,000 people on waiting lists for surgery in the United Kingdom for such operations as hernia repair, varicose veins, and hip replacements. However, a safety valve exists for certain procedures in the form of private-sector care.

In the previously discussed survey of Spaniards’ satisfaction with their health care system, respondents were asked whether, in the past year, they had to wait for any kind of medical test or service other than an
operation or a hospital admission. About 13 percent said they had to wait for some service. Of these, 23 percent were still waiting for the service they needed, and 75 percent eventually got what they needed but waited an average of 74 days. The study concluded that, “overall, in the course of the year, most Spaniards perceive they get the medical care they need, and they generally are satisfied with it. However, it is clear that some will have to wait rather long periods, and this situation could well explain their dissatisfaction with the National Health System’s organization.”

The most common reason for complaint among opponents of Australia’s Medicare system is the waiting lists for elective surgery in public hospitals. An Australian Institute of Health report cited in Health Affairs highlights the problems that arise from compilation of the lists by private physicians rather than by hospitals or state health authorities, with the high likelihood that patients would appear on more than one list. Physicians have broad discretion in determining which patients are put on the list and at what stage of their illness; this may allow the profession to tailor perceived waiting list crises to longer-term political strategies. In Australia, the line is a fine one between a booking list for routine elective surgery and a waiting list (Altman and Jackson, 1991).

In a National Public Radio report on health care in the Netherlands (see above), Dutch patients at Leyenberg Hospital said they often have to wait for elective surgery; the wait can be three months for cataract surgery, and eight to nine months for hip replacement.

When considering the policy implications of these observations for the United States, it is important to recognize that all of these examples of long waiting lines refer to government-operated systems of care and/or single-payer systems. Countries such as Germany and Japan, which provide coverage through a pluralistic system of private and public insurance funds with a choice of competing providers, do not seem to have these problems. Nevertheless, they deliver care at much lower cost than the United States. In addition, it is important to note that waiting lines may serve as a utilization control tool that assesses the patient’s real desire or need for elective services. In countries such as Japan, where there is significant cost sharing at the site of service, waiting lists may not be a necessary control.

As stated in the introduction to this paper, the countries that provide universal access to basic health care had to create a health care delivery system. In doing so, they had to develop priorities and processes in order to make difficult decisions. Within the benefit guarantee of the health care systems, some services had to be included and some excluded. Some included services were made available only to those who medically qualify, and some nonurgent services were only made available on a scheduled basis. While proponents of our pluralistic model may call this rationing, others would say it is both rational and humane. These countries have taken the position that society as a whole should set priorities through an organized decision-making process—one that attempts to spread the resources so that at least a basic level of care is available to everyone.

When the United States made the unique decision not to define personal health care as a public right, it also made the de facto decision that it was not the nation’s responsibility to plan for the effective and efficient delivery of health care services. As a result, the nation abdicated responsibility for defining the goals, priorities, budgets, human and technology resource needs, and the best methods of delivering personal health care. Instead, it fostered a patchwork quilt of

Coverage, Cost, and Quality
licensed providers, competing insurance plans, tax incentives, and governmental programs that produced poorly coordinated and duplicative systems of care. The degree to which this approach matches our uniquely American priorities and needs depends on one's view of how responsive health care is to free market forces. Most countries took the position that basic health care services could not be adequately distributed and disciplined by market forces due to the prilimal need for health services and the professional monopoly over the technical aspects of treatment choices.

Many health care experts maintain that rationing is not the answer to the health care delivery problem in the United States. Opponents of rationing health care point out that high costs and the lack of universal coverage are the result of an inflationary and wasteful health care system. According to Arnold S. Relman, M.D., rationing is not likely to be successful in controlling costs unless the United States deals with this basic problem. He writes:

New forms of technology and insatiable demand are not the fundamental causes of cost inflation, nor are overuse, inefficiency, duplication, or excessive overhead expenses. They are simply the manifestations of a system that has built-in incentives for waste and inflation. It is the way we organize and fund the delivery of health care that rewards the profligate use of technology and stimulates demand for nonessential services; it is the system that allows duplication and waste of resources and produces excessive overhead costs. Change certain features of the system, and you will not only reduce costs in the short run, but moderate the inherent forces causing inflation....To avoid rationing, what we require most is not more money but the will to change those aspects of the present system that are responsible for the present cost crisis (Relman, 1990).

Relman's comments bring this discussion back to the first question asked: how should one define rationing? His comments imply that rationing is the willful and inappropriate withholding of needed health care services due to budgetary constraints. This argument is a good one. With as much as $200 billion of our $800 billion health care bill reportedly due to inefficiency or waste, we can save a lot of money through health reform and better resource allocation, without even having to withhold needed appropriate care. The curious thing about the current argument between those who, like Schwartz, say we must acknowledge the need to ration, and those like Relman who say it's not necessary, is that they both essentially agree that the U.S. system of health care delivery must be fundamentally changed. Both would probably agree that we need systems in place that can make and implement resource allocation and prioritization decisions.

In comparing the U.S. system to that of our major economic competitors, one is led to the conclusion that the United States spends more than it should and distributes the benefits of that spending poorly. To significantly impact this problem will require major reform of the health care system. There are many different models for reform from which we can take ideas, although the final solution will certainly be uniquely American. The final design of any successful reform will need to be able to effectively manage all three components of the health care equation: access, cost, and quality. Whether we end up being much more efficient at providing good care to everyone (“good rationing”), or withholding appropriate care for purely economic reasons (“bad rationing”), may be as much or more a function of funding levels than of the specific design of the reform efforts. The more critical question is, can the United States afford not to put a system in place that has the ability to effectively manage cost, access, and quality?


In Japan, universal health insurance coverage was adopted in 1961. Today individuals are covered under several plans (table 1). Employees of large companies and their dependents are required to join health insurance societies that are formed at the company level and are a part of the public sector. The employees of small- and medium-sized companies and their dependents are required to be affiliated with a national government-managed health insurance plan. In both cases, the necessary insurance premiums are, in principle, borne by labor and management on a 50/50 basis.

The nonemployed—primarily composed of self-employed persons such as farmers and store owners as well as pensioners and the unemployed—are required to join health insurance plans that are operated by local governments. In this case, the expenses are covered by insurance premiums paid according to the insured’s income level and by subsidies provided by the national government (the amount is equal to that of insurance premiums).

Japanese health insurance programs employ a “benefit-in-kind” system in which medical care services are provided, and medical expenses under the programs are, in principle, reimbursed based on a fee-for-service method. Usually patients can freely select the hospitals or clinics where they wish to be admitted or visit doctors.

Approximately three-quarters of Japanese hospitals are operated by private organizations. The majority of hospital beds are in these hospitals. In addition, most of the clinics are managed by either private organizations or private practitioners. Much of Japan’s medical care is supported by the unregulated practitioner system.

Moreover, the National Treasury shares costs with some of the health insurance programs, narrowing the gaps among different medical insurance plans. Medical expenses that are to be reimbursable are first discussed and negotiated by the Central Social Insurance Medical Council (called “Chiukyo”) by those to be paid (clinics, hospitals, etc.), those who pay insurance premiums (employees, labor unions, insurers, etc.), and neutral third party representatives. After the members of Chiukyo reach a compromise, the national government makes a decision based on that body’s final conclusion. The same reimbursement tariff is applied to all Japanese medical insurance programs.

In past years, the youthfulness of the population and high economic growth supported our adoption of universal insurance coverage. In 1970, 7 percent of the Japanese population was aged 65 and over. Our country still had a relatively young population. With regard to the rapid growth of Japan’s economy since the latter half of the 1960s, I don’t think you need to hear much from me.

However, it is necessary to emphasize the following four points in addition to the population mix and the expansion of the national economy. First, many of the Japanese people had already been affiliated with one health insurance program or another by the latter half of the 1950s (table 2). By 1955, 68 percent of the Japanese public was covered by a health insurance program, while 32 percent was not. In other words, in the course of formulating a national plan, the Japanese government did not have to begin from scratch. In fact, it achieved universal coverage rather easily by improving or supplementing an existing program.

The second point is that the Japanese government eased opposition from the Japanese Medical Association by instituting a “fee-for-service” system at
the very start. This was considered necessary because during the 1950s Japan saw a remarkable increase in the number of doctors due to the repatriation of soldiers and military doctors from abroad. The Japanese government gained the support of these young and physically fit doctors by promising this “fee-for-service” system, which was very attractive to them. Essentially, the system embodied the principle that the harder you work, the more income you can earn.

The third factor was the Japanese people’s strong expectation with regard to welfare. Specifically, there was a strong yearning to create a society that would not allow the people to become impoverished as a result of illness or disease. The Japanese government actively addressed this issue and translated the people’s desire into reality.

The fourth point was government subsidies (table 3). There was a problem associated with small- and medium-sized business owners’ ability to bear the insurance premiums associated with universal medical insurance coverage. However, we solved this problem by affiliating employees of extremely small companies (with fewer than five employees) with the National Health Insurance Program. The National Treasury subsidizes 50 percent of the expenses for that program. We also affiliated those working for small companies (with five or more employees) with the Government-Managed Health Insurance Program. The National Treasury subsidizes 16 percent of this program’s expenses.

Japan has a 30-year history of providing universal insurance coverage for its people. During this period, moderation of health care expenditures has been constantly pursued. It would be no exaggeration to say that my predecessors and I, along with the current officials of the Japanese government, have made the moderation of medical care expenditures a primary policy goal.

### Table 1

<table>
<thead>
<tr>
<th>Plan</th>
<th>Persons Covered (millions)</th>
<th>Percentage of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Society</td>
<td>32</td>
<td>26%</td>
</tr>
<tr>
<td>Government-Managed Health Insurance</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td>National Health Insurance (Local Government-Managed)</td>
<td>43</td>
<td>35</td>
</tr>
<tr>
<td>Mutual Aid Associations (Public Service, etc.)</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>124</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Masataka Kohda.

### Table 2

<table>
<thead>
<tr>
<th>Plan</th>
<th>Covered (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s Health Insurance</td>
<td>32</td>
</tr>
<tr>
<td>(Societies, Government-Managed, Mutual Aid Associations)</td>
<td>29</td>
</tr>
<tr>
<td>National Health Insurance</td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
</tr>
<tr>
<td>Total Not Covered</td>
<td>29</td>
</tr>
</tbody>
</table>

Source: Masataka Kohda.

### Table 3

<table>
<thead>
<tr>
<th>Plan</th>
<th>Percentage of Government Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Societies</td>
<td>0</td>
</tr>
<tr>
<td>Government-Managed Health Insurance</td>
<td>16.4%</td>
</tr>
<tr>
<td>National Health Insurance (Local Government-Managed)</td>
<td>50</td>
</tr>
<tr>
<td>Mutual Aid Societies (Public Service, etc.)</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Masataka Kohda.

*Up to 1991.*
Over these many years, various ideas have been tried and endeavors undertaken for this purpose. One of the directions was to make patients aware of the cost of care. In 1984, Japan decided to impose a fixed rate copayment on the insured. Specifically, we amended the system to mandate that the insured bear 10 percent of their own medical expenses. In this way, patients can immediately know the total medical expenses by multiplying the copayment amount by a factor of 10.

Another effort involved the control of excessive medical services, including excessive tests and overmedication, by imposing medical consultation guidelines on doctors who treat patients. However, this effort met with severe opposition from the Japan Medical Association, which vehemently opposed intervention in the area of medical treatment.

Table 4 shows the national medical expenditures as a percentage of national income. It is not possible to accurately compare the national medical expenditures among different countries due to slight differences in the definition of such expenditures; however, the figures indicate that Japan's percentage is lower not only than that of the United States but also of many European countries.

Table 4: Health Care Expenditures as a Percentage of National Income, 1989

<table>
<thead>
<tr>
<th>Country</th>
<th>Expenditures as % of National Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>11.0%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>6.0</td>
</tr>
<tr>
<td>Former West Germany</td>
<td>9.5</td>
</tr>
<tr>
<td>France</td>
<td>10.7</td>
</tr>
<tr>
<td>Japan</td>
<td>6.2</td>
</tr>
</tbody>
</table>

Source: Masataka Kohda.

How has Japan managed to keep national medical expenditures at a relatively low level? In addition to the country's rapid economic growth and youthful population, I can cite two ways in particular:

- The negotiations held by the Central Social Insurance Medical Council (Chuikyo) enable the actual status of payment affordability and the desired reimbursement for medical expenses to be revealed clearly. The discussions during these negotiations have helped us to reach compromises on both points.
- The National Treasury's financial contribution has reached 50 percent at maximum (although the ratio varies among the medical insurance programs), and this arrangement, through the formulation of the national government’s budget, helps hold medical expenditure growth in check.

Although other diverse efforts have been made, we have not found a panacea that effectively addresses all our problems. But I think we have to tackle these challenges through a process of trial and error. I think a willingness to try new approaches to old problems is the most pragmatic way of facing up to the problems.

One cannot stress strongly enough that the moderation of medical care expenditures must be jointly tackled by all of the concerned parties. One of the characteristics of health care expenditure problems is that, while you can find a solution to moderate one type of health care expenditure, that solution may in turn invite a sudden expansion of expenses in another area.

While Japan's health insurance programs are quite uniform in structure and application, they are strongly public in nature; their American counterparts are essentially multidimensional and unregulated. These factors illustrate the differences between the two countries' health insurance programs. However, the need for national efforts to moderate and control health care expenditures is common to both countries.

Under these circumstances, the health insurance system in Japan is currently shifting from the traditional uniform approach to a multidimensional approach and moving toward the introduction of more private-sector involvement in addition to the conventional public-sector activities. On the other hand, the United States appears to be poised to aim at greater systematization, as symbolized by a potential introduction of universal coverage and other activities.

The health insurance systems in the United States and Japan seem to have taken different paths in the past. However, both countries are now moving closer to each other through the U.S. orientation toward systematization and Japan's movement toward a multi-
dimensional system and a public/private sector mix. It is likely that both countries share similar goals.

In this sense, I believe that both countries have the potential to learn a lot from each other. I think that the health care system in the United States can provide us a wealth of useful knowledge and experience which, in turn, can help us to shape our own health insurance system for the future.
Between 1981 and 1991, close to 100,000 families filed for bankruptcy because of catastrophic medical costs.

Between 1981 and 1991, more than 500,000 families filed for bankruptcy for reasons related to their health, such as the illness of a primary wage earner.

Expenditures for medical care have risen from 4.6 percent of disposable income in 1950 to approximately 8 percent in 1970 and to just short of 15 percent in 1990.

In 1990, expenditures for health care amounted to 61 percent of before tax corporate profits, up from only 8.4 percent in 1965.

The effect of rising health care costs on household income and corporate profits, combined with the failed attempts by large purchasers expending considerable resources in the marketplace to bring inflation under control, has pushed growing numbers of consumers and health care purchasers to support cost containment approaches that go beyond private-sector initiatives. These individuals are tired of the unrealistic promises about containing costs that have gone along with new marketplace products. What they want to see advanced are proposals that will work. On that basis, a cost containment strategy built around a global budgeting system would be an effective mechanism to reduce the rate of increase in health care costs.

This discussion identifies some of the issues that must be discussed if global budgets are to be implemented successfully.

At no time has the need to reform the health care system been perceived with such urgency. Chart 1 shows a selective breakdown of the composition of Gross Domestic Product (GDP) and the increasing share of national resources being allocated to health care. In 1990, health care accounted for 12.4 percent of U.S. GDP, compared with 9.0 in Canada, 8.1 percent in West Germany and 6.5 percent in Japan. If current trends continue, U.S. health care spending will reach 18 percent to 20 percent of GDP by the end of the decade. This upward trend has major consequences that have been addressed most recently by the Congressional Budget Office (CBO) publication Economic Implications of Rising Health Care Costs. In this report, CBO succinctly captures the effects of rising costs on the federal budget, state and local budgets, business, and American households.

For the first time it appears that a majority of Americans now favor government intervention...
to impose limits on the health care system. What is not yet clear is whether there is any consensus on what those limits should be.

Most individuals believe that the nation is spending more than enough on health care; they are allocating a growing share of their household budgets to out-of-pocket payments, uncovered services, and insurance premiums and have begun to question whether they are getting an appropriate return on this investment. They are concerned about the malpractice issue but are in the dark about how to make better choices among physicians and hospitals or managed care networks. They also are concerned about growing gaps in coverage, constraints on the availability of services in certain parts of the country, and administrative waste and red tape associated with the current fragmented system.

A global budgeting system is the only cost containment alternative that would involve the type of systemwide restructuring necessary to achieve the results that the American people expect but with the checks and balances and opportunities for involvement that will ensure their support. Here are its key advantages:

• It offers a predictable and effective strategy to contain costs;
• It can be implemented using a blend of regulatory and market-based approaches;
• It would force the United States to develop an overarching health care policy and a strategic planning process that would involve allocating resources in a forum with broad public participation;
• It would require the development of a management information process that would track volume and performance as well as price; and
• It would require a process to determine the efficacy of new technology, as well as a broad capital policy.

Global budgeting is the only alternative that will allow us to establish systemwide goals and give us a mechanism to determine whether those goals are being met. Absent such goals, consumers and purchasers will continue to give a blank check to the health care system.

Several points should be made about how global budgeting compares with other cost containment approaches. While an all-payer rate setting system would impose constraints on reimbursement and address the cost-shifting problem, it would not adequately address volume (i.e., numbers of services performed, practice patterns, etc.). The other major shortcoming of an all-payer system is that its reimbursement methodology (diagnosis related groups and the resource based relative value scale) may be inappropriate for entities that successfully begin to manage care. On the other hand, an all-payer approach could work effectively as one of the mechanisms to contain fee-for-service costs within a global budgeting system.

Another cost containment alternative frequently mentioned is managed care, which would involve changing incentives in the current system so that networks of providers can compete against one another. The theory is that government intervention would discourage the development of a true health care market. While a number of individuals have offered impressive testimony about the potential of such efforts, it is hard to be optimistic about a pure market-based strategy based on the experience with health maintenance organizations and preferred provider organizations. On the other hand, managed care might operate more effectively within a global budgeting system in which performance goals are established and progress is measured.

There are a number of key decisions that must be made in designing a global budgeting system. First, agreement must be reached on the system’s overall structure. There could be a cap on the share of GDP allocated to health. There could be a specific national budget that would be expressed in terms of dollars, or there could be a
targeted rate of increase. Clearly, each of these options has advantages and disadvantages, and other design alternatives are possible. One of the advantages of a targeted rate of increase for the system would be its flexibility. Another advantage is that the methodology used to achieve the cap could span the gamut of the strategies being discussed in this forum, including changing physician behavior, all-payer rate-setting and, if warranted, explicit rationing.

Second, decisions will have to be made about how the program is to be administered. The experience with Medicare has been that Congress makes very specific design decisions, effectively micromanaging the system, with input from the Prospective Payment Assessment Commission, the Physician Payment Review Commission, and the U.S. Department of Health and Human Services. One of the most important decisions that must be made should the global budgeting policy option be pursued, is whether it is to be developed by Congress and administered by a federal agency or whether Congress gives power to an independent body to develop, monitor, and (conceivably) implement the system.

The ability to implement successfully what is envisioned is a dynamic system with the participation of all of the major stakeholders is in its design and execution. A broadly representative public-private body or commission would allow decisions to be made that have the support of consumers, purchasers, and providers and make it more difficult for government programs to shift costs to employment-based plans. If there ever were compelling reasons to pursue explicit rationing, the broad-based governing authority could ensure that such policies would not be confined to certain sectors of the population. In other words, the commission would provide a public forum to debate the underlying ethical issues associated with any policy moves toward rationing and ensure that some of the concerns about equity raised in the context of the Oregon initiative would be addressed.

Third, the issue of control over the system will involve decision-making about how to balance decisions to be made at the federal level versus decisions made by the state. There are a number of questions that must be answered, including should separate targets be allocated to each state, how will an allocation formula be developed that reflects the needs of cities versus rural areas, how will variations in health care costs across states be handled, and how will variations in provider practice patterns be put into the mix? Once these and other budget decisions are made, what will be the states' responsibilities? Should they be given flexibility to develop their own cost containment systems to meet their budgets? What steps will be taken if states exceed their targets?

Fourth, if we are to be successful in changing the incentives in the system, a limit also must be placed on increases in capital expenditures that would force the development of a new process to review capital expansion and acquisition of new technology at the state and local level. Given the strong linkage between capital spending and operating costs, we cannot hope to reduce the rate of growth in health care costs without including capital in the global budgeting system. To carry out such a process fairly and equitably, there should be state or regional commissions similar to those being proposed at the federal level.

Fifth, the issue of how far reaching the global system should be is another matter that will play a part in the development of a reformed system. Specifically, there will be debate on which expenditures are to be included in the system and which expenditures are not. All services incorporated into whatever core benefit package is specified under a national health care system should be included under a global budgeting system.
Whether the objectives outlined above can be achieved will be contingent on additional design decisions that should be identified and discussed, including:

- Public acceptability and participation in the process: If the President desires to pursue a global budgeting strategy, it will be crucial that he explain to the public what the objectives of the system are before the system begins to work.
- Establishing separate targets for the fee-for-service and managed care sectors: The advantage of a global budgeting system is that appropriate cost containment strategies can be designed for different parts of the system, while maintaining an overall limit on expenditure growth. This would ensure that the development of effective managed care products is not discouraged, while both types of delivery systems are measured.
- Ability to standardize, collect, and track data to measure costs in the system, as well as perform sectoral analyses: Data from all payers will be crucial for establishing baselines for the global system and monitoring effectiveness. We must move forward with a uniform national plan to develop a standard claims form as well as electronic information transfer systems so that consumers and purchasers can be more informed about the cost and quality of services rendered.
- Ability to measure performance (outcomes) in private and public delivery systems: As discussed previously, enforcement of global budgets would involve the volume as well as the price of services provided. Significant progress still needs to be made in the area of outcomes research before the quality as well as volume of services can be assessed.
- Flexibility of the system to absorb new challenges and priorities: A global budgeting process must allow for the type of continuous feedback and flexibility that can accommodate changes in spending priorities, new health care challenges, or the development of new technology. At present, because the system is so fragmented we absorb new procedures without an adequate technology assessment process, different entities are developing their own practice guidelines, and third party payers are analyzing limited health care data.
All-Payer Rates: Bringing Order to the Health Care Market

G. Lawrence Atkins, Ph.D., director of employee benefits policy, Winthrop, Stimson, Putnam & Roberts

Introduction

All-payer rates have been proposed as part of a comprehensive strategy to bring order to our chaotic health care market and control rapidly rising health care costs. Often viewed as one of the transferable ideas from successful European systems, all-payer rates are actually one of the few cost containment strategies already tested and found effective in the United States. While no single approach to cost containment can work throughout our complex health care system, all-payer rates would provide an effective starting point for coordinating public- and private-sector efforts. As part of a comprehensive program, they could provide the basis for a more efficient allocation of resources in the health care system. At a minimum, all-payer rates would eliminate the seemingly endless shifting of costs from strong to weak payers that now passes for cost management and focus efforts on providing cost-effective care.

Definition

In an all-payer system, every payer pays the same price for the same service. All-payer means simply that all payers (e.g., private payers, managed care entities, Medicare, and Medicaid) pay a particular provider the same price for a particular type of service. Rates may vary by provider, but for any one provider all payers must pay the same rates.

The term all-payer system encompasses a variety of approaches to developing rates. The basic concept in an all-payer system is that rates developed by some public or quasi-public body have the force of law for all providers and payers. Beyond this basic concept are a tremendous number of variations. All-payer rates can be set or negotiated, developed nationally or locally, and be uniform for all providers or provider-specific. Rate setting may be imposed arbitrarily by the federal government (e.g., requiring providers to accept Medicare diagnosis related groups (DRGs) and resource based relative value scale (RBRVS) payments from private payers) or imposed by a state rate-setting commission. Negotiation between providers and payers may be conducted at the national level to determine uniform rate schedules or at the state or local level to establish either uniform rate schedules or provider-specific rates.

All-payer rates may be applied to any of a number of different reimbursement methodologies. Rates may compensate for services performed on a unit basis, such as per diem rates for hospitals or fee-for-service for physicians. Alternatively, they may place providers at financial risk, through any of a number of different approaches, including Medicare-like prospective payment for hospitals (based on DRGs), bundled or global fees (combining physician and hospital payments), or capitation.

The Rationale

All-payer rates are needed to end cost shifting and limit total health care spending. The ability of providers to shift costs among payers currently prevents the actions of any set of independently operating payers from influencing the overall supply of medical care. In a health care market divided into several public and private segments, providers are able to raise prices for one sector to cover losses in another and attain predetermined revenue targets. Discipline imposed by individual payers (such as Medicare’s aggressive price setting) influences
their share of expenditures but not the level of total expenditures. Only coordinated action by all payers can overcome market segmentation.

All-payer rates would limit total provider revenues and force more cost-effective health care decisions. All-payer rate negotiation would establish a limit on total revenues and force providers to reduce costs rather than shift costs. The influence of all-payer rates on total revenues would also provide the basis for reducing excess hospital capacity, limiting capital investment, and properly allocating new technology.

All-payer rates would force government to fully finance the care it provides to its own beneficiary population. All-payer rates would apply to Medicare and Medicaid as well, forcing the government to fully finance the care for federal benefit recipients. Raising Medicaid reimbursement rates to the level of costs would substantially reduce hidden taxes of 20 percent to 40 percent on private plan payments to providers. By providing fair Medicaid payment, it would expand the population of physicians willing to accept Medicaid recipients.

All-payer rates would encourage more efficient investment decisions in health care free investment capital for other uses in the economy. Excessive spending on health care results, in part, from a market failure that prices resources as if they were limitless. Without a limit on health resources, the economy will continue to redirect needed resources from other sectors for use in health care. Not until total resources are constrained will prices be set and resources allocated on the basis of their value to the society.

An all-payer strategy can quickly and decisively bring costs under control. Cost containment approaches such as managed care or managed competition aimed at influencing the delivery of services require a time-consuming restructuring of the health care delivery system. Meanwhile, health care costs will more than double by the end of the decade (rising from $800 billion to more than $1.6 trillion in 2000). An all-payer system can be implemented quickly and without a major restructuring of the existing system of financing and delivering health care.

America's experience with all-payer systems, though limited, has been largely successful.

Twenty-seven states had some form of hospital rate setting at some point in the 1970s. Studies of general hospital rate-setting efforts show that they reduced the growth in hospital costs, with particular success in the states that had mature systems in place. A study of the experience between 1973 and 1983 in states with mandatory rate setting showed that hospital inflation was consistently 3 percent to 4 percent lower in states with mandatory rate setting than in other states (Schramm, Renn, and Biles, 1986).

Only four states ever had true all-payer systems—with Medicare involved. Maryland started its system in 1971, obtained its waiver to include Medicare in 1977, and today is the only state with Medicare still in its all-payer system. New Jersey obtained its waiver in 1979 and ended it in 1988. Massachusetts included Medicare from 1982 to 1985, and New York included it from 1983 to 1985. All three of these states continue to operate all-payer systems without Medicare.

All-payer systems were adopted largely as a strategy to aid hospitals and insurers and were not solely intended to control costs. In some states, they followed on the heels of more stringent rate setting and were intended to relieve financial pressures on hospitals and level payment rates between Blue Cross plans, which benefited from substantial hospital discounts, and commercial insurers. The three states that discontinued their waivers did so largely in response to pressure from hospitals that felt they could get higher payments under Medicare’s new prospective payment system.
Maryland's experience with more than 20 years of all-payer hospital rates has been particularly instructive. Maryland has maintained a slower rate of growth in hospital costs per admission than the national average, lowering its costs from 25 percent above the national average in 1976 to 10 percent below the national average in 1991. A common criticism of rate setting is that by lowering per diem rates, it encourages an increase in admissions or lengths of stay. However, Maryland hospital admission rates have declined along with the national downward trend in admissions, and today Maryland's per capita hospital costs are 14 percent below the national average. Another concern about hospital rate setting is the resulting incentive to shift care to unregulated, nonhospital settings, maintaining high overall health care costs. While Maryland's hospital controls have encouraged a growth in nonhospital services, this trend is not inconsistent with the national growth in ambulatory and outpatient care resulting from the tightening of Medicare prospective payment rates. Control of total health care expenditures would require an extension of all-payer methodologies to the totality of health care services.

### Community Negotiated Rates: Rochester, NY

Rochester, NY has demonstrated the effectiveness of community negotiated rates. Rochester's efforts with cooperative regional health system management have kept its health costs well below the national average.
The Rochester model, which evolved over 25 years, today combines community negotiation of hospital budgets and provider rates and regional health planning with community rating of insurance premiums and an emphasis on HMOs.

By most measures, the Rochester effort has been an unqualified success. Its community planning has reduced excess hospital capacity and prevented the proliferation of expensive technologies—two problems that have plagued other cities. Rochester has successfully closed under utilized hospitals and restricted risky and costly medical procedures to a few high-volume centers. As a result, Rochester hospitals operate more efficiently than the average U.S. hospital—filling 87 percent of its bed capacity compared with the national average of 67 percent (Taylor, 1987).

Rochester health care costs have risen at an annual rate nearly 4 percent below the national average. Costs per employee today are only two-thirds the national average ($2,378 as opposed to $3,573 in 1991). HMO premiums are lower as well (Xerox family HMO premiums were 73 percent lower for Rochester employees than the average for Xerox nationwide in 1986) (Taylor, 1987).

At the same time, Rochester residents report a much higher level of satisfaction with their health care system than the average American. More than one-half of Rochester’s population is enrolled in HMOs, and HMO patient satisfaction exceeds 96 percent. Overall, 84 percent of Rochester residents report they are satisfied with their health care, compared to only 71 percent of Americans.

Global Budgeting and All-Payer Rate Setting: Germany

The German experience with global budgeting and all-payer rate-setting has demonstrated that these techniques can work in a multiple-payer environment to control costs. Germany has been relatively successful in controlling health care costs despite the fact that it has a mixed public-private financing system with more than 1,100 private insurance funds, a private medical care system, and cost containment that is negotiated between providers and payers.

German national expenditures are governed by a global budget. A 1977 law states the principle that average health insurance premium increases should not exceed wage growth. A biennial national health conference translates this principle into recommendations for sickness fund contribution rate increases. Germany’s 1,100 private sickness funds then negotiate with physicians and hospitals to determine payment rates that will meet the national target. The funds negotiate quarterly lump-sum payments and fee schedules with regional physician associations. Unanticipated increases in utilization that would raise total spending above the lump-sum amount are offset by reductions in the fee schedule. The funds also negotiate operating budgets with hospitals. State and local governments fund hospital capital budgets and the federal government regulates drug prices (Iglehart, 1991; Reinhardt, 1989).

The German cost containment law has helped to hold health care expenditure growth below the growth rate for the economy. During the 1980s, while American health spending exceeded economic growth by an average of 33 percent a year, Germany’s health expenditures exceeded its growth by only 3 percent. Between 1985 and 1990, Germany’s health spending actually declined as a share of Gross Domestic Product from 8.7 to 8.1 percent (Iglehart, 1991).
effort to control total expenditures must apply to all settings to avoid the tendency to simply shift costs out of controlled settings.

There is little experience in the United States in applying all-payer systems to outpatient settings, group practices, individual physicians, or any other non-hospital providers or settings. It is difficult to know, in advance, how to successfully structure physician rates in an all-payer system.

Foreign experience shows success in negotiating physician fees but is not directly applicable to the United States. Most other countries separate hospital and nonhospital physicians, making it possible to pay for hospital care and ambulatory care on separate bases. In the United States, most hospital care is ordered by nonhospital based physicians, making it necessary to coordinate physician and hospital payment approaches. The United States also does not have the luxury of being able to work with truly representative physician groups that could negotiate or enforce professionwide agreements.

Strategies to Control the Volume of Services

Controls on the unit price of health services inevitably encourage an increase in the volume of services. All-payer rates will need to be linked to global budgets or expenditure targets to incorporate disincentives to proliferate services.

Medicare's current fee schedule, based on a RBRVS, includes an annual adjustment for volume performance standards (VPS). In essence, utilization that exceeds the VPS becomes the basis for reducing a future increase in the fee schedule.

Global budgets or expenditure targets would presumably work in much the same way as Medicare's VPS. Any percentage increase in expenditures exceeding the targeted expenditure level would lead to a similar percentage reduction in rates the following year.

While volume adjustments may effectively control total expenditures (by simply recouping overruns in subsequent years), they contain perverse incentives that reward high volume providers at the expense of low volume providers.

Nevertheless, all-payer rate negotiation provides payers the tools to influence provider decisions and behavior along a number of dimensions. Ultimately, payers can restrict payments for nonapproved capital expansion, unnecessary services or equipment, or excessive volume.

Incentives

An all-payer system will have to include incentives for efficiency and quality in health care delivery. An all-payer system that used uniform rates for providers could reduce or eliminate the incentives for hospitals and physicians to provide services efficiently or for consumers to make price-sensitive choices. Uniform rates could also prevent payers from rewarding and encouraging high-quality providers.

To encourage cost-conscious behavior in providers, Medicare and some private carriers have adopted risk-based payment systems. Prospective hospital payments based on diagnosis (DRG), for example, are used by Medicare to place providers at risk for excess utilization. Uniform prospective payment schedules impose the incentives for managing care entirely on the provider. They eliminate the potential for payers and patients to save money by making cost-conscious choices—either in the selection of a hospital or in managing the length of stay—because payers make the same payment regardless of the choices made.

While uniform rates would hypothetically interfere with incentives to select efficient providers, none of the all-payer states used purely uniform rates. Instead, they tended to use blended rates that mixed payer and provider incentives for efficiency. States using DRG-based payment combined the hospital incentives for efficiency in DRGs with payer incentives for prudent choice by blending rates based on statewide and pro-
vider-specific costs. Non-DRG states based their rates on actual provider costs and made adjustments over time to encourage the inefficient providers to lower costs.

Prospective (DRG-based) payment also prevents payers from being able to save money by managing the length of stay. Payers in a DRG system pay the cost of an average length of stay regardless of the amount of care provided. Maryland’s use of hospital per diem payments has been viewed by some as having been successful in encouraging more active management of care by payers.

Negotiated rates can also be adjusted to reflect known differences in the quality of providers or to reward high quality providers, once reliable information on process and outcomes differences is available.

Innovation

An all-payer system should encourage the continuing evolution of alternative payment systems and more efficient approaches to the delivery of services. New approaches to organizing delivery systems and paying providers offer hope for reducing unnecessary care and improving the efficiency of the health care system. While rigid all-payer approaches might force uniformity in rates and block innovation, an emphasis on more flexible all-payer models could encourage innovation.

There is some indication that the growth of alternative models has not been deterred in the all-payer states. Three of the four all-payer states are among the top 12 states for percentage of population enrolled in HMOs. Massachusetts was the number two state in 1991, with enrollment of 30 percent of the population; Maryland had 18 percent enrollment; and New York, 16 percent, compared with 14 percent nationwide. Rochester, NY experienced unusually strong HMO growth rates in the 1980s during the height of its planning efforts, at a time when HMO growth nationally had slowed. Today, 55 percent of Rochester’s population is enrolled in HMOs— one of the highest concentrations in the country (Interstudy, 1991; Blue Cross/Blue Shield of the Rochester Area, 1992).

The design of an all-payer system will have a major effect on the incentives to develop alternative payment approaches. All-payer systems that vary rates for providers, emphasize rate negotiation, reward payers who manage utilization, and exempt fully integrated delivery systems from negotiated rates offer the greatest potential for encouraging and rewarding innovation in payment methodologies.

Principles for an All-Payer System with Locally Negotiated Rates

National Reform and National Guidelines—Failed cost containment efforts in the past were launched as experiments and plagued by tentativeness and indecision. Only a national commitment to cost containment can assure the ongoing dedication of resources necessary to make an all-payer system work, including the involvement of federal programs (e.g., Medicare). National guidelines would enable enough similarity among state approaches to reduce incentives for health costs and/or businesses to move across state lines.

Local Implementation and Decisionmaking—Health care in the United States is inherently a local activity with wide variations nationwide in the nature and cost of health care delivery. Uniform national rates would force providers to operate at average cost levels—too high in some areas and too low in others. Efforts to limit or restructure health resources should be built on state- and local-level experience and local relationships between payer and providers.

Negotiation and Cooperation—Rates imposed arbitrarily by an outside party are likely to encourage providers and patients to game the system. All-payer approaches built on a cooperative effort to control costs
e.g., Maryland, Rochester) have been the most successful. Cooperative efforts to control costs that have failed in the past have largely lacked resource limits that could force community groups to make tough decisions (Brown and McLaughlin, 1990). Negotiation within the confines of global budgets or expenditure targets could be more successful.

Incentives for Efficiency—While markets cannot operate properly without resource constraints, limiting unit prices for health services is not, by itself, a panacea for rising costs. Greater efficiency and quality in the delivery of medical care will require changes in medical practice, motivated, in part, by financial incentives for providers. The all-payer rates and the process of negotiating them must be focused on creating the incentives for more efficient medical practice patterns.

Incentives for Managed Care—At the same time, the structure of negotiated rates can have a substantial effect on the incentives for payers to develop or join managed care networks. Negotiated all-payer rates can and should be developed that would enable networks to continue to benefit from the selection of low-cost and/or efficient providers and from the management of hospital admissions, lengths of stay, and other aspects of the treatment plan.

Implementing a Locally Negotiated All-Payer System

Establishing a Local All-Payer System—Many states and local communities now have health councils, cost containment commissions, or business health coalitions that would serve as the basis for new all-payer councils. Federal law would provide funding for the councils and require each state to establish a state council or statewide network of local councils.

State/local councils would have representation from payers (Blue Cross, insurers, large employers, small business groups, and consumers) and providers (hospitals, physicians, allied professionals, and other institutions).

Initially, state/local councils would be responsible for collecting and entering claims data; preparing annual reports on local health care costs; publishing information on providers and their rates; and collecting and publishing information on hospital and physician quality measures. Data prepared initially on provider costs would serve as the basis for negotiating baseline all-payer rates.

Eventually, each council would be responsible for negotiating local rates with providers for use by all payers, including Medicare and Medicaid. The rates would be a floor and a ceiling —there would be no discounts permitted from the negotiated rates and no balance billing to patients.

The Role of a National Council—The national council would provide guidelines for establishing local all-payer councils, establish uniform data standards, and maintain a national data base on claims.

The national council would also prepare national and state expenditure targets, based on congressional guidelines, and would publish an annual statistical report on actual health care spending and the causes of expenditure increases.

Incentive for All-Payer Councils to Control Costs—All-payer councils would be motivated to control costs to slow the growth in premiums for payers and to maintain Medicare and Medicaid participation in the all-payer rates.

Initially, the national council would adopt a sequence of annual expenditure targets aimed at a gradual slowdown in the rate of growth in health care spending. National targets would be converted to state targets based on a blending of each state's current share of national costs and the average national per capita cost for health care.

State expenditure targets would initially provide state and local all-payer councils a reference point for evaluating and designing local cost containment efforts. Within five years, the targets would become the basis for negotiating local all-payer rates.

Medicare's Participation in Local All-Payer
Systems—Medicare (and Medicaid) would pay the negotiated rates but would not participate in the negotiating process. Medicare and Medicaid payment of all-payer rates equivalent would be necessary to end cost shifting and give the council influence over total spending. Medicare and Medicaid would be excluded from the negotiations to prevent government domination of the market. Congress’s authority to control Medicare expenditures would be preserved through its control of the expenditure targets.

Medicare and Medicaid participation would begin once the local all-payer councils were operational and would continue in each year that average state expenditure growth over the prior three years is equal to or less than the state target.

Failure by a state to meet its expenditure target on average in the three preceding years would result in the withdrawal of Medicare and Medicaid from the all-payer system and their return to paying rates set by the federal government. Medicare and Medicaid would return to the all-payer system once a state demonstrates success in meeting the expenditure target.

State/Local Councils Would Negotiate All-Payer Rates—Each state/local all-payer council would be responsible for negotiating provider-specific all-payer rates. Baseline rates would be negotiated individually with each provider in much the same way as managed care networks now negotiate provider agreements. Rates would be both a floor and a ceiling, with no option for a payer to negotiate a discount or pay less than the rate (to avoid a reversion to cost shifting). With the exception of deductibles and copayments specified in the health plan, payments by the plans at the all-payer rates would be considered payment in full with no balance billing above the rates to patients.

Negotiations with hospitals would address each hospital’s annual costs and revenues in relationship to community averages, planned capital improvements, anticipated technology acquisition, excess bed supply, and underutilized specialty practices. Agreed-upon revenue targets would be converted to department-specific rates for all payers.

Negotiations with physicians would be based on prevailing fee schedules, with negotiated reductions or increases based on mitigating circumstances, productivity, and quality measures. Rates agreed on by the council and providers would apply to every patient, with no balance billing to any patient above the rate.

Baseline rates would be adjusted annually based on updates negotiated by the council. Negotiations would be based on increases in state expenditure targets, adjusted down to reflect expenditure increases in excess of prior year targets.

The Influence of All-Payer Rates on Capital and Technology—The local council would review and approve all plans for significant purchases of equipment and facility construction or expansion. Negotiated rates would include assumptions regarding amortization of approved purchases. Nonapproved purchases could not be financed through the all-payer rates.

Encouragement of Organized Delivery Systems within the Scope of an All-Payer System—Organized delivery systems that provide comprehensive health care services to enrolled members for a single annual capitation payment would be exempt from the all-payer rates. The exemption would apply only to payments to providers or facilities with an exclusive relationship with the delivery system. Payments to hospitals or physicians who serve more than the members of the organized delivery system would use the all-payer rates to prevent unfair discounts and cost shifting to other payers.

State expenditure targets would be disaggregated into two targets: one applied to all-payer rates and the other applied to organized delivery systems. The target for organized delivery systems would be a function of their capitation rates. Annual all-payer targets would be modified to account for increased enrollment in organized delivery systems.
Competition strategies (such as managed care) and regulatory strategies for controlling health care costs both operate from a premise of market failure in health care caused by weak and ineffective buyers of health services. While competition strategies promote competition among knowledgeable purchasers (i.e., managed care entities) as a way to impose greater discipline in the market, all-payer approaches promote cooperation among buyers as a way to end cost shifting and place limits on health care resources.

Advocates of competition criticize all-payer approaches for interfering with the proper functioning of markets and creating perverse incentives for providers by price setting. All-payer approaches that use uniform rates are viewed as eliminating the benefits to consumers of provider selection and predating price-based competition among providers. Uniform rates are also faulted for preventing the use of payment incentives to providers that would encourage efficiency and quality. Price controls of any kind are viewed as an incentive for providers to increase the volume of services; and the elimination of provider discounts and other aspects of all-payer reimbursement are viewed as discouraging the growth of managed care as a means of controlling utilization.

These concerns are appropriate in response to some all-payer approaches, but certainly not all. Approaches that would rely on federal rate setting, impose uniform rates on all providers, and transfer the financial risk entirely to providers would leave little room to develop managed care. Their success in cost containment would depend solely on their ability to control total health expenditures by lowering reimbursement rates.

However, all-payer rates developed through local negotiation between payers and providers may work quite differently. Locally negotiated, provider-specific rates would enable payers to continue benefitting from provider selection and the direction of patients to network providers. Reimbursement methods that are structured to provide incentives for managing utilization and improving quality, and that would permit the emergence of alternative payment methodologies, would encourage innovation in controlling health care costs.

The chief benefits from implementing all-payer rate negotiation would be to end the provider cost shifting that has prevented the actions of individual purchasers in the past from influencing overall expenditures and to have this significant effect on expenditures before the end of this decade.


Brown, Lawrence D., and Catherine McLaughlin. “Constraining Costs at the Community Level: A

Bibliography

Schramm, Carl J., Steven C. Renn, and Brian Biles. “Controlling Hospital Cost Inflation: New Perspectives on State Rate Setting.” Health Affairs (Fall 1986): 22–33.
Medical resources can be allocated to enhance the quality of care provided and to control costs by reducing the amount of unnecessary or inappropriate care and ensuring that medical intervention is preventive, timely, and continuous rather than reactive and episodic.

This article discusses two ways that enhance quality and control costs: the use of primary care physicians as gatekeepers and the use of fee schedules for provider reimbursement.

Physicians have argued loudly and convincingly that they, rather than their patients or payers, should allocate resources, making pivotal decisions about the kind and quantity of care required by their patients. Their knowledge of available diagnostic and therapeutic modes, combined with their familiarity with the unique details of each patient’s history, make them uniquely qualified to determine patients’ needs. Rather than submit to the scrutiny of outsiders, such as utilization review organizations, that make medical decisions based on statistics and create layers and layers of additional paperwork and bureaucratic morass, most physicians seem to prefer assuming management for their patients.

This discussion assumes there is merit to the argument described above. If scarce resources are to be allocated, we must consider alternatives to reviews of physician behavior by individuals who do not know the patient and whose services may not be cost effective.

Recent studies have found that many employers do not think utilization review has been effective in controlling costs. Furthermore, some argue it has limited access to care without improving the quality of the care given. Others argue it has actually increased administrative costs without offsetting savings.

The use of the primary care physician as a gatekeeper places the responsibility for medical decisionmaking squarely on the shoulders of a physician who knows his or her patient best and, theoretically, is best able to determine the patient’s needs.

A gatekeeping system creates a clearly defined point of entry into the health care system each time care is required. Patients do not have to try to diagnose themselves by deciding whether they should see a neurologist or an orthopedist for back pain. In fact, the patient is required to see the primary care physician who is familiar with his or her medical history and current medications. That primary care physician usually evaluates the patient’s symptoms and determines whether specialist care is required. If the symptoms and clinical indications suggest the need for a specialist, the primary care physician refers the patient to the specialist, receives reports back from the specialist, and coordinates the patient’s care. The primary care physician frequently diagnoses and treats the condition rather than referring patients to specialists.

Controlling Costs

In many managed care systems, primary care physicians are encouraged to make cost-effective decisions by accepting some financial risk for their decisions. For example, they are encouraged not to order duplicative tests or refer patients unnecessarily. Risk sharing mechanisms vary but frequently involve a withholding of a certain percentage of the physician’s salary, capitation fee, or fee for each service that may be returned at year end, depending on financial or quality outcomes or both.
A gatekeeper system offers clear advantages in terms of both cost and quality. It can avoid unnecessary or duplicative care, thus controlling costs. Patients who self-refer tend to see specialists more frequently than those who participate in a gatekeeper system. Since specialty care is more costly than primary care, gatekeeping controls costs.

Enhancing Quality

A gatekeeper system also can enhance quality. It assures coordination of care by eliminating both duplication and gaps in care when numerous providers treat a patient but no one assumes responsibility for overall coordination. A single patient record is maintained as well.

Most studies that compare treatment of primary care physicians and specialists show that primary care physicians tend to deliver less intense (and costly) care with no difference in quality. Some studies suggest that care from primary care physicians may be superior to specialist care because primary care physicians are more likely to provide continuity and comprehensiveness.

Controlling Access

Other quality enhancements offered by a gatekeeper are more subtle. A gatekeeper helps patients navigate our complex and often intimidating health care delivery system, relieving some of the stress caused by encounters with the health care system.

A gatekeeper system controls access to care. Many believe the gatekeeper’s control of entry into the system is an effective method to allocate resources by assuring they are used appropriately. Some critics of this system, however, are concerned that gatekeepers with a financial stake in limiting care may be tempted to withhold necessary care. While this possibility seems plausible, studies of the effect of gatekeeping with financial incentives have found that primary care gatekeepers do not withhold beneficial care for financial reasons. Nevertheless, to the extent possible, we suggest that assignment of bonuses or allocation of the withheld dollars must be done on the basis of quality factors such as outcomes and performance of preventive procedures, as well as financial outcomes, in order to minimize the risk of undertreatment.

Allocating Resources

The use of primary care physicians as gatekeepers, who serve as patient advocates to guide their patients through the health care system, offers one way to allocate resources by limiting unnecessary, costly specialist care. However, as long as specialty care continues to receive more emphasis than primary care, it will be necessary to attempt to shift emphasis in our health care system toward services that encourage prevention and continuity.

The use of fee schedules can serve to diminish rewards for high intensity specialty care as well as to complement efforts to manage utilization by using gatekeepers. Fee schedules offer an alternative to the traditional methods of physician reimbursement, the usual, customary, and reasonable (UCR) system used by most employer-sponsored group medical benefit plans and the customary, prevailing and reasonable system used by Medicare prior to the introduction of the resource based relative value scale (RBRVS).

The UCR approach is inherently inflationary. It provides physicians an incentive to set their prices as high as possible at the outset. If enough physicians in the community do so, the “customary” portion of UCR will be high. And, a physician who consistently bills at a high level will assure that the “usual” portion of his or
her profile will be high as well. Only the “reasonable” portion of UCR remains to serve as a check on high prices, but “reasonable” is a very subjective concept and is used as often to adjust a fee upward as downward.

Some also argue that UCR is inflationary because it is set to reimburse the full cost of all but the most expensive providers in a community, blinding patients to the actual cost of the care they receive and providing no incentive for the patient to seek providers with lower charges.

Finally, once a UCR fee is set for a new procedure, there is little incentive to reduce that fee as technology is improved and the procedure becomes simpler, less time consuming, and less costly to conduct. Cataract surgery is an example of a significant reduction in the time required for a procedure without an accompanying reduction in the fees charged by surgeons.

Historically, UCR has rewarded specialties that perform procedures, whether those procedures are diagnostic, surgical, or therapeutic, rather than specialties that spend time listening to patients, educating them, diagnosing them, and coordinating their care.

Medicare’s RBRVS approach to physician reimbursement represents a major shift in physician reimbursement. It is based on the belief that physicians should be reimbursed for the costs of delivering a particular service. The four key cost factors used in development of the scales were the time spent by the physician, the intensity of effort required, the practice costs associated with a given specialty, and the opportunity cost of training required. The Health Care Financing Administration (HCFA) subsequently rejected the opportunity cost component and has limited the specialty cost component to malpractice insurance costs.

In spite of HCFA modification and criticisms of the subjectivity of the method used to set reimbursement levels, the relative value approach provides the opportunity to adjust the balance in physician reimbursement and to correct inequities in the UCR schedule. For example, reimbursement for evaluation and primary care consultation can rise and reimbursement for high-tech procedures in surgery and radiology can be reduced.

However, even if the methodology used to develop the RBRVS were corrected to make it more objective, and other criticisms of the system addressed, it would not be practical for most private payers to implement RBRVS because they lack the political and economic clout of Medicare. Nevertheless, some statewide Blue Cross Blue Shield Plans, such as Utah’s, are implementing physician reimbursement on the basis of a modified RBRVS.

Few private payers, individually, represent a significant proportion of total medical payments in a given area to impose such a system without shifting costs to their employees. If providers do not agree to accept the plan’s payment schedule as payment in full, plan participants may be required to pay the difference between allowable charges and billed charges. Medicare participants are being protected against such actions by legislation, but private plan sponsors cannot protect plan participants in the same way. Nevertheless, plan sponsors in the private sector can overcome many of the disadvantages of a UCR system by developing a maximum allowable charge system that provides more flexibility, greater control, and relief from external constraints.

Whether a fee schedule is used to encourage plan participants to seek providers whose charges are within the specified limits or the plan sponsor uses it as a basis for negotiation with physicians to develop a provider network for participants, the fee schedule can ensure uniformity and equity in payment to providers, along with direction and predictability.

Employers who join together in coalitions or other group purchasing arrangements such as those in Cleveland or Minneapolis can extend their clout and actually change both practice and billing patterns in their community through the use of fee schedules.
Conclusion

The cost of providing medical benefits has become an almost unbearable burden for some employers, and efforts to expand access to health care for the more than 35 million Americans who are uninsured can be expected to increase total expenditures for health care in the United States. It is clearly essential that we develop means to allocate resources, but it does not follow that care must be rationed. Instead, the use of primary care gatekeepers can enhance quality and control costs, eliminating unnecessary care and ensuring that needed care is provided at the appropriate level. Fee schedules can be used to eliminate perverse incentives in our current reimbursement system that foster increases in physicians' charges and to make physician reimbursement more equitable, rational, and controllable.

Both offer promise and merit consideration and trial.
Explicit Rationing/The Oregon Proposal
Mark Gibson,
health policy consultant and former chief of staff, Oregon State Senate President

To deal with the unrelenting economic and public policy pressures associated with the crisis in health care cost and access, Oregon has established a process—a framework in which fundamental reform and cost control in our health care system can take place. This point should be emphasized. The Oregon Health Plan\(^1\) should not be viewed as a definitive solution but rather as an ongoing process to achieve consensus on our policy goals and the principles that will guide our health policy and as a framework in which resource allocation and reallocation can take place.

Perhaps the most distinguishing characteristic of the Oregon plan is the explicit nature of the resource allocation process it establishes. It baldly states the issues that must be resolved in health care resource allocation and imposes unrelenting accountability on policymakers for the decisions they make and the consequences of those decisions. It eliminates the tools of implicit health care rationing used by states, businesses, and the federal government today, and replaces them with an open, clearly defined, resource allocation process that combines considerations of clinical effectiveness and social value with fiscal responsibility. It provides the citizens of our state a forum within which they can debate the relative desirability of various health services, a framework in which they can better evaluate the relative benefit of health care spending, compared with spending on other social support programs, and a financial formula that inextricably links societal expectations with the costs of delivering them.

The Oregon plan begins by providing health care access to virtually all Oregonians. This is financed by state general fund taxation in partnership with the federal government by granting Medicaid eligibility to all Oregonians with incomes below the poverty level, regardless of categorical status, and by employers in partnership with employees through the requirement that employers provide (on a cost shared basis) coverage at least equal to that received by Medicaid clients. These provisions, linked with extensive insurance reforms and a high-risk pool for persons excluded from the insurance market due to pre-existing conditions, extend health coverage to virtually everyone.

Thus, Oregon changes the current health care debate from who is covered to what is covered. To determine what constitutes “adequate basic coverage” for Oregonians, the plan creates a commission charged with rank ordering health services according to their benefit in a process that considers both clinical effectiveness and social values. The ranked list is then priced by an independent actuary at levels sufficient to deliver the prescribed services through a managed, prepaid, capitated delivery system. The legislature is statutorily prohibited from changing the order of items on the list, nor can it change eligibility standards or reimbursement levels for providers. Instead, it must start at the top of the list, funding each item in turn, until it reaches a point where it deems additional revenue is better spent elsewhere.

The advantages of such a process are many. Perhaps the most important, however, is that it creates a contextual background for the consideration of health-related resource allocation issues that enables us to make better informed decisions as we attempt to maximize the effectiveness of our programs. This is apparent

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\(^1\) For a complete description for the Oregon Health Plan, see Appendix A.
on two fronts. The first is intramedical and the second is interprogrammatic.

The Intramedical Context

The importance of the intramedical context is well illustrated by the Illinois decision in 1984 that provided state-funded organ transplants for those without other insurance coverage at the same time the state was closing inner city health clinics due to the lack of funds, and 60 percent of black preschoolers were not properly immunized. This decision was only possible because the legislative process allowed policymakers to consider the organ transplant issue isolated from the other unmet medical needs in Illinois. Thus, legislators there took credit for highly visible surgeries that “saved lives” without being forced, at the same time, to justify why they were letting other needs go unaddressed, which would undoubtedly “cost lives.”

By contrast, the Oregon process forces policymakers to be accountable for all the unmet medical needs in the state. It forces policymakers to confront the reality that the health care budget is limited, and that when choices are made within those limits, funding one service means that another is not funded. This in turn provides a structure that supports policymakers in dealing with narrowly focused interest groups as they make difficult but logical decisions regarding how to allocate resources. Legislators deliberate within a clearly defined framework that insures that primary care and preventive services are provided to everyone before infertility services are provided to certain subgroups; that life-saving treatments for pneumonia and appendicitis are covered before treatments that are only marginally effective in improving wellness.

The Interprogrammatic Context

The benefit of establishing an interprogrammatic context can be illustrated by considering why we buy health care services, the difficulty states have in funding other social support programs as medical costs continue their rapid upward spiral, and the impact cutbacks in other areas might have on the health status of our population. Obviously, the only real value associated with health care services lies in their ability to improve health. Moreover, not all health care services are equally beneficial; some are only marginally effective, some are futile, and others are only used for minor conditions. Just as obvious is the fact that proper housing, while not a health care service, has an important impact on health. The same can be said about programs that prevent crime, that mitigate environmental problems, and that lessen domestic violence. All have a profound effect on the health status of our population.

Clearly, if we blindly increase the amount we spend on health care without regard to the effect this has on these other programs, we run the risk of creating worse health outcomes than if we had properly balanced spending between the two areas. The Oregon process makes clear exactly what services will be included by additional investments in health care. The desirability of these health care services can then be more readily compared to the desirability of other possibilities for social spending and investment.

Another major advantage of the Oregon approach stems from the fact that policymakers and the public are forced to confront the true costs of their expectations and program preferences. One of the most serious shortcomings of the current system is that it insulates both consumers and policymakers from the true costs of the care they receive and mandate. Moreover, the current relationship of expectations to costs is further skewed by the use of cost shifting and other implicit funding sources. These funding sources amount
to hidden taxes that are notoriously difficult to guide through deliberative public policy.

By contrast, the Oregon plan specifically identifies the responsibilities of the third party payers in its system, both in the public and private sectors. It then uses an independent actuarial process to establish reasonable costs associated with providing the care it prescribes. This pricing process is integrated with the state budget process in such a way that services cannot be included in the plan without also providing adequate funding to pay for their delivery. Thus, the Oregon plan is inextricably linked to the actual cost associated with delivering the care.

This results in several advantages. First, it guarantees that providers are paid at sufficient levels to actually assure access as opposed to the current system, which in many cases underpays providers to such an extent that many who have "coverage" fail to receive care because providers refuse to take them as patients. In addition, it assures that sufficient revenue is provided to support desired levels of quality in the delivery system. Moreover, by clearly identifying the cost of an expensive social program to both the public and private sectors, it forces policymakers to confront the impact of their decisions not only on other government programs but also on the business community, which is crucial in maintaining the employment base and economic viability. Perhaps most importantly, this approach guards against the tendency among policymakers to provide popular services to their current constituents and then pass the costs of those services on to future generations through deficit spending.

**Effective self-government relies on accurate information, clearly framed choices, and clear accountability. The explicit nature of the Oregon Health Plan provides these supportive elements in creating a credible health policy for the state.**

**Conclusion**

Oregon Health Plan Update

On March 19, 1993, the Clinton administration informed the state of Oregon that it had approved the state's Medicaid waiver request. In her letter to Governor Barbara Roberts, Secretary of Health and Human Services (HHS) Donna Shalala cited the administration's support of state innovations by saying, "The President believes that the federal government must give states the flexibility to design new approaches to their local problems, provided that these proposals meet federal standards." Her letter then referenced terms and conditions that the state would be required to meet before being allowed to proceed.

The federal Medicaid guidelines waived under the five-year demonstration waiver pertained to the amount, scope, and duration of services, allowing the state to design its own benefit package by using its priority setting process. Uniformity of service requirements was also waived, allowing the state to maintain a traditional Medicaid program for the aged and disabled until these populations could logically be integrated into the demonstration project. Federal eligibility standards were waived, allowing the state to broaden Medicaid eligibility to all persons with an income below the federal poverty level regardless of category and to simplify eligibility by using only a gross
income test. The state will be allowed to restrict choice of provider in order to maximize the use of prepaid managed care and will be able to reimburse managed care systems at rates higher than the current-fee-for-service rates, which are generally too low to cover the cost of care given Medicaid clients. Under the waiver, the state may elect to deliver federally qualified community health centers (FQHC) and rural health clinic (RHC) services through managed care organizations and reimburse them accordingly. Finally, while still required to provide all screening and preventive services to children under early periodic screening diagnosis and training (EPSDT), the state is not required to provide treatments that have been deemed ineffective by the prioritization process.

There were 29 “Special Terms and Conditions” placed on the Oregon waiver. Most were related to reporting requirements, evaluations of performance, the submission of proposals for modifying the demonstration, confidentiality of records, expenditure caps, and verification of sufficient capacity to adequately serve the new eligibles. All of these were anticipated by the state and posed little difficulty. However, three specific conditions merit further discussion.

The first was the requirement that the Oregon Health Services Commission, the group responsible for priority setting under the Oregon process, redo the priority list, “without relying on the data which it collected with respect to whether treatment returned an individual to an asymptomatic state.” This referred to the methodology used by the commission that first ranked treatments based on their effectiveness in preventing death and then on the effectiveness of the treatment in eliminating the symptoms associated with the condition being treated. HHS lawyers theorized that, because some disabilities were virtually synonymous with symptoms, this would place the plan in the position of discriminating on the basis of a disability and thus would open it to accusations of violating the Americans with Disabilities Act (ADA). While the state vigorously disagreed with this assertion, citing the fact that the condition was irrelevant to their ranking and that the ranking depended solely on the effectiveness of the treatment in dealing with the condition, the commission agreed to modify their methodology rather than delay the expansion of the Medicaid program further. Left unanswered were questions of why the ADA would be interpreted in such a way that it would view the ineffective treatments for disabling conditions any differently than it would view ineffective treatment for any other condition.

The second item under “Special Terms and Conditions” related to the commission’s placement of treatments for conditions causing infertility. HHS had no quarrel with the fact that the Oregon program would not cover some infertility services. In fact, HHS made it abundantly clear that the state was not required, under federal Medicaid regulations, to cover any treatment whatsoever for infertility. However, HHS expressed reservations regarding the existing Oregon priority list based on what it saw as the possibility that the commission gave infertility services a low ranking because the condition was deemed to be less serious than many other conditions on the list. Thus, HHS said that the state was allowed to arbitrarily exclude infertility services from their process; but if infertility services were included in the process, they could not be ranked based on the nature of the condition, but rather must be ranked on the basis of “content neutral criteria” which had no connection to the “disabling state” of being infertile.

The third item required the state to insure that providers would render all medically appropriate, funded treatments for a given condition before denying any other treatment related to that condition because it was given a lower priority and thus not funded by the legislature. Moreover, the administration required the state, especially in the case of “an individual with a disability or co-morbid condition,” to provide a treatment that was not funded by the legislature if the treatment could be shown to have an outcome comparable to a funded treatment. A telephone information line for appeals and information related to this issue was required for “expeditious resolution of questions raised by providers and beneficiaries in this regard.”

The state is moving aggressively to meet all of the terms and conditions set forth by the administration. The Health Services Commission met on March 25, 1993 to reorder the list in accordance with the administration directives. The Oregon Department of Human Resources Office of Medical Assistance Programs is working to meet the other requirements in a timely fashion. Even though the state is experiencing a significant revenue shortfall, officials are optimistic that agreement will be reached on a way to adequately fund the demonstration project. Expansion of the Medicaid program is scheduled to begin approximately six months following final action on the state’s budget. The requirement for employers to offer health insurance to all permanent employees and their dependents is scheduled to begin in July 1995.
Appendix A

The Oregon Health Plan

The rising cost of medical care and the growing number of people unable to afford even routine care threatens the health as well as the social and economic well-being of this country. The root of the problem lies both in the lack of a national health policy and in the lack of any rational and accountable process of health care resource allocation.

The Oregon Health Plan is one state’s response to this crisis. The plan clarifies the state health policy, creates a rational and accountable resource allocation process, and establishes a clear framework in which comprehensive health care reform can take place. The Oregon Health Plan is the result of a broad-based, bipartisan agreement among health care providers, health care consumers, business, labor, and insurance companies.

The origins of the current crisis date back to 1964 when President Johnson’s task force on health reported that “the aged and children in low income families faced the greatest financial barriers to access” and recommended the enactment of publicly financed hospital insurance for the elderly and the expansion of maternal and child health programs for poor children.

As a consequence an historic decision was made to move from a private system to a public/private system. In July of 1965 President Johnson signed into law two dramatic amendments to the federal Social Security Act: Medicaid and Medicare.

It is very important to recognize, however, that when the federal government became directly involved in the provision of health care, the policy objective was not to ensure universal access but rather to improve access for those interest groups or “categories” who, in 1965, were perceived to be facing the most serious barriers. In other words, the government was responding to an immediate problem but not in the context of any comprehensive long-term policy. While the objective was access to health care, it was not universal access to health care. Thus, Medicaid and Medicare are based not on a policy of universal access but rather on a policy of access based on category.

Medicaid is a program not for all poor people as many think, but rather only for certain “categories” of poor people. To be eligible for the Medicaid program one must fit into a congressionally designated “category” such as families with dependent children or the blind or disabled. Just being poor is not enough. Poor men and women without children, for example, are ineligible even though they may be deeply impoverished. Furthermore, women without children must actually become pregnant in order to qualify for coverage—a situation which ignores the obvious relationship between the health of a woman before conception and her ability to carry and deliver a healthy infant.

Medicare, on the other hand, is a federally administered “entitlement” program for those in the category “over the age of 65.” It is not means-tested which means that everyone over the age of 65 receives publicly subsidized health care regardless of whether they are impoverished or retire on $2 million a year.

Nonetheless, these two programs, along with the growth of private employment-based insurance policies, gave most Americans access to some form of third party insurance coverage. But because universal access was never the policy objective, there were many who fell through the obvious gaps in this public/private financing system: primarily those under the age of 65, who do not meet the categorical or income eligibility requirements for Medicaid, who are not offered work-place-based
coverage, and yet who cannot afford the cost of care themselves. But because of our fee-for-service reimbursement system which allowed us to cost shift, these people were still treated and the costs simply shifted to people who could pay by increasing either their insurance premiums or their bills.

Widespread third party insurance coverage and the ability to cost shift created the illusion that health care was free, since both providers and consumers were insulated from the true cost of treatment decisions. Consumers began to expect not just access to the health care system, but also to everything the system had to offer, including the latest high tech and even experimental procedures. Providers, on the other hand, could enjoy the luxury of employing all treatments available, regardless of cost, as long as some potential benefit, however slight, might result.

Not surprisingly, this system encouraged a dramatic and unchecked escalation in costs by hiding true costs both from those receiving treatment and from those giving treatment—someone else paid the bill. Health care costs rose from $1 billion a month in 1950 to over $11.7 billion a day in 1991. Last year America spent $650 billion on health care, this year we will spend nearly $800 billion. By the middle of this decade our national health care bill will top $1 trillion dollars.

As a result of these astronomical cost increases, the major third party payers—the government and employers—began to look for ways to shield themselves from what was becoming a serious financial liability, taking actions which have had the very real effect of creating enormous barriers to access for a substantial part of our population. These “cost-containment” actions, listed in the following paragraphs, neither contained costs nor stemmed public expectations. The costs were simply shifted back onto providers and consumers while expenditures continued to escalate.

The federal government has shifted costs and economic risks to providers by enacting the Diagnosis Related Group (DRG) program, a prospective payment system, and to individuals by increasing Medicare first-day hospital deductibles and Part B premiums for Medicare physician services. In addition, Congress has progressively shifted costs to the states through a series of Medicaid “mandates” which states must offer or risk losing their federal matching funds. These mandates require that states give eligible persons all services, whether they are effective or not. Congress makes optional other highly effective services such as mammography which would reduce the number of deaths from breast cancer, a disease Medicaid will pay to aggressively treat after a patient is diagnosed. These mandates are bankrupting the states which, unlike the federal government, must balance their budgets.

States have responded in two ways: by changing Medicaid income eligibility standards and by cutting provider reimbursement rates. Changing Medicaid eligibility standards shifts costs to individuals and amounts, in effect, to “redefining the poor”—throwing people off the program to balance the budget. The average national Medicaid eligibility is currently below 50% of the federal poverty level, which means that in many parts of this country, a family of three making more than $5,785 is considered too rich to qualify for publicly subsidized health care.

By drastically cutting provider reimbursement rates, states shifted costs to providers, many of whom now refuse to see Medicaid recipients at all. Those who do often shift uncompensated costs to employers, driving up their insurance premiums. Businesses have reacted by contracting with Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), shifting costs and risks to providers; and by adding co-payments and deductibles, and increasing employee contributions, they have also shifted costs to individuals.

Those employers who continue to provide coverage to their workers are actually paying three times, not only for the cost of coverage for their own employees but also through higher premiums caused by cost-shifting, for under-reimbursement in the public sector and for the costs incurred by workers without employment-based coverage.
For 25 years, then, our ability to provide universal access has depended not on a conscious public policy, but rather on our ability to cost-shift and on the willingness of the government and employers to absorb the cost of that shift. Between 1965 and around 1980, most of those costs were absorbed by the government and by employers, thus spreading them out over taxpayers and over most of the work force. One could make a cogent argument that society was paying the cost of universal access. But with the "cost-containment" measures instituted in the 1980s, more of these costs were shifted to the provider community which had less ability to absorb them. What used to be subsidized care in a practice or institution began to show up as uncompensated care. And when a provider or institution reached a point of being unable or unwilling to absorb any additional uncompensated care, they began to require that individuals pay the costs themselves.

So in 1992, those without health insurance or private resources are likely to lose access to the health care system, squeezed into a growing coverage gap, either because a provider cannot be found to treat them or because they avoid or delay seeking treatment out of concern for how to pay for it. Today this gap contains around 35 million Americans and 450,000 Oregonians, the majority of them workers and their dependents. The most obvious consequence of this "non-system" is the rationing of health care: premature infants dying from respiratory distress because their mothers did not receive prenatal care; children dying of treatable spinal meningitis; young adults in diabetic coma, with lobar pneumonia, with serious wound infections—all because they delayed seeking treatment because they did not know how they would pay for it.

The situation has a number of serious implications from the standpoint of health—both in the traditional sense of the word and in terms of the social and economic health of the nation. Not only is the physical health of the nation suffering, we are crippling our ability to increase national productivity relative to our major foreign competitors and restricting our ability to make domestic investments in education, civilian research and development, environmental protection, and the infrastructure on which our future economic and thus social viability depends.

There are currently 450,000 Oregonians—one out of every six citizens—who go without routine health care because they have no health insurance coverage and yet cannot afford to pay the cost of care themselves. Of the uninsured in Oregon, 120,000 live in poverty but do not qualify for Medicaid; 280,000 are from working families whose employers are dropping or reducing insurance coverage because of health care cost inflation; 20,000 cannot get coverage because of preexisting medical conditions; and the remaining 30,000 do not purchase insurance coverage for a variety of reasons.

The Oregon Health Plan is based on two premises: (1) the reality of fiscal limits; (2) the need for accountability.

Reality of Fiscal Limits

Legislators at all levels are acutely aware that there is a limit to the level of taxation the public will tolerate. But states, unlike the federal government, do not have the luxury of operating with a deficit, because they are constitutionally required to balance their budgets. They thus clearly understand that there is a finite budget from which to fund all activities of state government. (Oregon, for example, has balanced its...
budget every year since it was admitted to the union in 1859, while the federal government faces an estimated fiscal 1992 budget deficit of nearly $400 billion.) And while health care for the poor is unquestionably a governmental responsibility, it is by no means the only responsibility. States must also fund public education, law enforcement, transportation systems, and a variety of other social programs. But as health care costs increase, states must either raise taxes or cut these other programs, many of which themselves may have a direct bearing on health. Thus, the Oregon Health Plan is predicated on an honest recognition of fiscal limits.

Need for Accountability

If we accept the fact that the health care budget, like any other budget, is ultimately finite, it follows that an explicit decision to allocate money for one set of services means that an implicit decision has also been made not to spend money on other services. That, in essence, constitutes the rationing of health care, and legislative bodies do it every budget cycle. But it is rationing done implicitly, and for which there is no accountability.

The current fiscal process allows public policy makers to take credit for “saving the life” of a highly publicized child who needs an organ transplant while assuming no accountability for the 40,000 American children who die each year before their first birthday. The only difference is that they are not right in front of us on the nightly news—they are invisible, even though many of them die preventable deaths as a result of implicit social and legislative decisions for which there is no accountability.

The current fiscal process allows us to make these allocation decisions in a vacuum. The Oregon Health Plan, by contrast, requires policymakers to make health care resource allocation decisions explicitly, to weigh the overall social costs and benefits involved, and to assume clear accountability for the decisions themselves and for their consequences.

Policy

Knowing what you want health care reform to accomplish is an essential first step, yet it is amazing how many “reformers” have never really defined the policy objective. What are we trying to accomplish? Is the objective to guarantee all citizens access to health care? Or is it to keep all citizens healthy? Obviously it is, or should be, the latter, and if the objective is to keep people healthy, we must recognize that health care is not necessarily synonymous with health. Health care is but a means to an end—not an end in itself.

Infant mortality, for example, reflects more than just a lack of prenatal care. It also reflects environmental problems, housing problems, teenage pregnancies, and the enormous problem of substance abuse. We cannot improve the health of our nation if, for example, we continue to spend money only on the medical complications of substance abuse, yet ignore the social conditions which lead to addiction in the first place. And that means investing in things like education, housing, environmental problems, income maintenance, and economic opportunity. But as health care costs increase, it becomes ever more difficult to make significant investments in these other social areas which would keep America far healthier.
Principles

The Oregon Health Plan is an attempt to develop not simply a health care policy, but a health policy; an integrated approach in which resource allocations for health care are balanced with allocations in related areas which also affect health. Having established a common policy objective, however, it is not enough to effect political change. To achieve the objective a series of incremental explicit choices must be made. Each choice has associated with it a different set of political and policy implications and a different effect on a diverse set of political stakeholders representing vested and often conflicting interests. To ensure that these interests remain focused on the broad policy objective—and to make sure that this focus transcends their narrower concerns, Oregon did not start with a completed “plan” but rather with a consensus on a set of principles which would guide the reform effort. The principles are:

1) Allocations for health care must be part of a broader allocation policy which recognizes that health can only be maintained if investments in a number of related areas are balanced.
2) The resource allocation policy must include a mechanism to establish clear accountability for the allocation decisions themselves and for their consequences.
3) Universal access to a basic level of health care must be afforded to all Oregon citizens.
4) Society has an obligation to provide sufficient resources to finance a basic level of care for those who cannot afford to pay for it themselves.
5) A process to determine what constitutes a basic level of care must be established.
6) The criteria used in this process must be publicly debated, must reflect a consensus of social values, and must consider the common good of society as a whole.
7) The health care delivery system must offer incentives to use services and procedures that are effective and appropriate rather than those that are of marginal or unproven benefit.
8) The distribution system must avoid creating incentives for over-treatment.
9) Funding must be explicit and the system must be economically sustainable.

Expansion of Medicaid (Senate Bill 27)

Senate Bill 27 extends Medicaid to an additional 120,000 impoverished Oregonians. This expansion, along with the elimination of categorical exclusions, established a definition of the poor based strictly on need. All these individuals will receive a package of basic medical services prioritized according to a consideration of social value and their relative clinical effectiveness. To retain federal matching funds Oregon requires a waiver from the Health Care Financing Administration allowing the State to include coverage for “non-categorical” persons (e.g., childless couples or women without children) and to redesign the current mandated Medicaid benefit package. Granting of the waiver will trigger the provisions of the employer [play or pay] mandate described below.

Employer Mandate (Senate Bill 935)

Implementation of the Medicaid expansion alone would still leave about 330,000 people uninsured, 280,000 of them workers or the dependents of those who are working. Senate Bill 935 requires employers to provide health insurance coverage to all “permanent”
employees (working 17 1/2 hours per week) and to their dependents by July 1995. Those employers who voluntarily offer coverage prior to July 1995 will receive a series of tax credits and are exempted from current state insurance mandates. Employers not providing the required insurance coverage by July 1, 1995 will be required to pay into a state pool which in turn will purchase insurance coverage for their employees. If 150,000 employees are enrolled prior to the July 1995 deadline, the mandate will not go into effect. The benefit package required by the private sector must be “substantially similar” to that offered under the Medicaid program.

High Risk Pool (Senate Bill 534)

Senate Bill 534 created the Oregon Medical Insurance Pool which provides health insurance to Oregonians who are unable to obtain coverage due to medical conditions. There are approximately 20,000 Oregonians in this category. The 1987 legislature created the pool as a non-profit entity. It became a funded state agency in 1989 and first offered coverage in July of 1990. The pool provides coverage to those denied health insurance, those with restrictive riders on existing policies, or those who have to pay charges well above standard premium. Heart disease, cancer, diabetes, and respiratory ailments are among the problems that have prevented the pool’s clients from receiving insurance from conventional sources. The pool is supported by assessments of Oregon’s health insurance carriers and the premiums paid by enrollees.

Small Group Insurance Reform (Senate Bill 1076)

Senate Bill 1076 has three major components:
- Enacts significant reforms in the small group insurance market (defined as employee groups of three to 25) to make affordable insurance available to small businesses as they meet the requirements of Senate Bill 935. These reforms include:
  - guaranteed issue of coverage
  - guaranteed reissue of coverage
  - prohibition of exclusions based on preexisting medical condition
  - rate bands
  - limitation of underwriting to geography and family size and composition only
- Creates a process to convert the prioritized Medicaid benefit package (including mental health and chemical dependency services) to a private sector insurance product for both the indemnity market and HMOs. This process is being undertaken by the 11-member Small Employer Carrier Advisory Committee (SECAC). The SECAC has finished the design of this “basic health care plan,” and it should be on the market in late 1992. By 1995, and with ratification by the legislature, this standard benefit package will replace existing state insurance mandates and become the basic minimum requirement for all policies written in the state of Oregon.
  - Establishes a process to prioritize and integrate mental health and chemical dependency services into the basic benefit by 1993 (see “Expanding Coverage to Other Services”)

Expansion of Coverage to Other Services

When Senate Bill 27 was passed in 1989, the Health Services Commission was statutorily required to establish a subcommittee on mental health and chemical dependency to develop a process for the prioritization of these services. Senate Bill 1076 now requires that the services actually be integrated into the full priority list for funding by the 1993 legislature. (For the 1992-93 fiscal year, the mental health and chemical dependency services will be provided to Medicaid recipients as a separate budget item. With approval of the 1993 legislature they will be integrated into the full priority list for the 1993-95 biennium.)
Expansion of Coverage to Other Groups (Senate Bill 44)

Senate Bill 44 establishes a process by which the standard benefit package will be offered to aged and disabled persons on Medicaid by 1993 subject to ratification by the legislature.

Cost Containment (Senate Bill 1077)

Senate Bill 1077 establishes the Health Resources Commission charged with developing a clinically based process to control the excess acquisition and use of expensive medical services and technologies. (See “Cost Containment,” p.69.)

Universal Access

The development and implementation of the Oregon Health Plan spanned the 1989 and 1991 legislative sessions. We started with the premise that everyone should have access to the health care system and that Medicaid reform by itself is not enough. Those eligible for Medicaid constitute only about one third of those who are losing access to the health care system. From a state perspective, then, if we do not solve the access problem of the “working poor” as well as the access problems inherent in the current Medicaid program, we will continue to have an enormous cost shift, increasing pressure on the overall budget, and increasing competition for funds between health care and other programs, rendering the management of this problem virtually impossible.

Senate Bill 27 extends Medicaid eligibility to all persons below the federal poverty level, thus establishing a definition of the poor based strictly on need as opposed to category. Senate Bill 935 mandates comparable employment-based coverage (with the costs split between the employer and the employee) for the “working poor”.

To ensure that an affordable insurance product will be available as small employers begin to assume their responsibility under the Plan, the legislature passed Senate Bill 1076 to force small group insurance carriers to compete on the basis of price, product, and quality—not on the basis of avoiding risk.

Defining the Benefit

By guaranteeing that virtually everyone in the state will have access to the health care system, this approach significantly shifts the debate from who is covered to what is covered and creates a framework for beginning to evaluate the effectiveness and appropriateness of the actual services we are buying with our health care dollars. This is an important point because nowhere in either the public or private health care systems is the question of “What Is Covered?” ever directly addressed. The Medicaid requirement that “all medically necessary” services be offered ignores the fact that today a “benefit” or what is deemed “medically necessary” is often simply an intervention, divorced from its actual result in improved health.

This observation has an important implication for the development of public policy. Since it is the cost of the care or “benefit” package for those who have health insurance which forces both public and private payers to take actions which systematically exclude other people from the system, a consideration of exactly what constitutes a “benefit” must necessarily play a significant role in resolving the crisis (i.e., cost shift). This means that individual medical services must be evaluated on the basis of their efficacy and cost-effectiveness.

Prioritization Process

To determine the nature of Oregon’s “benefit” package, Senate Bill 27 established a Health Services How the Plan Works
Commission, an 11-member body appointed by the Governor and confirmed by the Senate after public hearings and consisting of five primary care physicians, a public health nurse, a social worker, and four consumers. One of the consumers served as chairperson. The Commission was charged with reporting a comprehensive list of health services ranked in priority from most to least important, judged by criteria of clinical effectiveness and social values.

To carry out its charge, the Commission developed a methodology based on the prioritization of medical “condition/treatment pairs.” The condition/treatment pairs were gleaned from two widely recognized classifications of treatment and diagnosis: the Physicians’ Current Procedural Terminology (CPT-4 codes) and the International Classification of Disease (ICD-9 codes). The actual determination of clinical effectiveness was based on a literature search and on the input of panels of physicians who were asked to provide certain clinical information about each condition/treatment pair in their areas of practice. Over 7,000 hours of volunteer time were given by Oregon physicians to this effort.

The Commission also developed an extensive, broad-based public process which took into consideration and attempted to integrate the values society felt should be used to guide health care resource allocation decisions. Under the auspices of an organization called Oregon Health Decisions, 47 town hall meetings, involving over 1,000 citizens, were held around the state to generate this kind of input.

On February 21, 1991, after 18 months of work, the priority list was completed. It consists of 709 condition/treatment pairs divided into 17 categories. The categories are prioritized based on the Commission’s interpretation of the social values generated from the public involvement process. Within each category the ranking of the condition/treatment pairs reflects the health improvement likely to result from each procedure for a given condition. (see Appendix A1)

Fiscal Process

The fiscal process was consistent with the underlying premises of the program: recognizing fiscal limits and establishing clear accountability. To accomplish this the final priority list was given to an independent actuarial firm which determined the cost of delivering each element on the list through managed care. This list and its accompanying actuarial data was given to the legislature on May 1, 1991.

Senate Bill 27 prohibits the legislature from altering the order of the priorities as established by the Health Services Commission, so in May and June of 1991, the Joint Ways and Means Committee, starting at the top of the list, determined how much could be funded from available revenues and what additional revenues would be needed to fund an acceptable “basic” package. In this way, the benefit level (or, “What Is Covered?”) is directly linked to the reality of fiscal limits.

The old options of cutting provider reimbursement or changing eligibility levels were not available to the 1991 legislature. Reimbursement had already been determined by the actuary, and the state could no longer arbitrarily “ration people” for reasons of budgetary expediency. Everyone retained coverage: universal access. Instead, the debate centered on the level of that coverage—what we as a society are willing to fund, and thus guarantee, to all our citizens.

Because the Committee did not have infinite resources, it was clear that increases in the health care budget must necessarily come at the expense of other programs such as education, housing, or corrections. This enabled the legislature to begin to develop an overall health policy—a policy which recognizes that health can be maintained only if resources in a number of related areas are responsibly balanced.

Finally, because of the priority list, because the tools of implicit social rationing have been statutorily eliminated, and because it was clear exactly what services would be included by incremental increases in expenditure level and what services would not be
included, the legislature is now clearly and inescapably accountable not just for what is funded in the health care budget, but also for what is not funded—a major departure from the congressional resource allocation process.

The 1991 Oregon legislature appropriated $33 million dollars in new revenue which funded all condition/treatment pairs through line 587 on the list of 709. The resulting benefit package, with its strong emphasis on primary and preventive care, is eminently defensible. It covers virtually all current Medicaid mandates, including all preventive and screening services, as well as a number of important services not required by Medicaid including: dental services, hospice care, prescription drugs, routine physicals, mammograms, most transplants, and physical and occupational therapy. (see Appendix A2 on p.72) This benefit package serves as the minimum standard not only for the Medicaid program but also for the 280,000 Oregonians who will come into the system on the employer side in 1995, at which point it is expected that this will become the standard for all policies written in the state.

Provisions Enacted

Managed care and prevention
Oregon’s statutory emphasis on managed care and the high priority given in the benefit package to preventive and primary care will contribute significantly to cost control over time.

Controlling health care resources
Senate Bill 1077, passed by the 1991 legislature, represents a landmark effort to control the costs associated with the excessive acquisition and use of medical facilities, technologies, and services. With the creation of the Health Resources Commission, Oregon will develop a clinically outcome-based method to control these costly and often redundant health care resources.

Evaluation of the Effectiveness of Medical Services/Procedures
While the priority process is not primarily designed to control costs it does provide a framework in which the effectiveness of medical services and procedures can be evaluated. As better outcomes data is generated this framework will increasingly contribute to cost reduction. The Bio-medical Information Communications Center (BICCC), currently operating at Oregon Health Sciences University, will contribute to this process.

Provisions in Progress

Modification of Physician Practice Patterns
This represents one of the major potentials for cost-containment. While most people think that two physicians in two different places treat the same problem in the same way, there is, in fact, a tremendous variation in the way individual physicians practice medicine. And while physician fees themselves do not constitute the largest percentage of overall health care costs, physicians’ decisions control over 70 percent of those costs. They decide who will be hospitalized, for what and
how often, who will get which procedure, and what drugs to use.

To understand the problem which this creates, consider the condition/treatment pair: Acute appendicitis/appendectomy. While there is universal agreement on the treatment for this diagnosis, one physician may hospitalize the individual for four days post-op, another for only three; one may order more diagnostic tests than another; one may use “prophylactic” antibiotics while another may not. Enormous costs are generated here—often unnecessarily. This was demonstrated by Dr. John Wennberg in his classic study comparing differences in hospitalization rates between Boston and New Haven, Connecticut. Wennberg revealed that physicians in Boston hospitalized patients twice as often as did the physicians in New Haven, without significant differences in outcome. Furthermore, he demonstrated that Bostonians spent $300 million more a year than they would have if the hospitalization rates in New Haven had been applied.

The methodology developed by the Health Services Commission currently focuses on “hard” treatment decisions—that is, those that involve explicit judgments about the efficacy of alternative treatments for specific conditions and the quality of life which results. It does not, so far, consider “soft” treatment decisions, that is those which are made more implicitly, according to the experience and clinical judgment of the physician, such as whether or not to hospitalize a patient for a given condition or what diagnostic test to order. Thus variations in practice patterns (which may or may not correlate with better health outcomes) are not currently factored into the methodology being employed by the Commission, yet we realize they contribute significantly to cost.

To begin to address this problem, a small area analysis was commissioned last year to look at the differences in hospital utilization in 33 different hospital markets in Oregon. The variation in hospital utilization rates revealed that a clear distinction can be drawn between “low-variation medical conditions” and “high-variation medical conditions.”

Low-variation medical conditions are those for which there is a firm consensus that treatment must take place in a hospital setting (hip fracture, heart attack, and most major surgery). Admission rates per 1,000 population for these conditions show very little variation from one Oregon hospital market to another.

High-variation medical conditions, on the other hand, are those for which there is considerable disagreement about whether or not hospitalization is indicated (pneumonia, chronic obstructive pulmonary disease, gastroenteritis, and back pain). Hospital admission rates for these conditions varied widely from one hospital market to another from a high of 335 days/1,000 people in Roseburg to a low of 142 days/1,000 people in Lakeview.

Reducing these variations offers a potential for significant cost savings. For example, if the admission rate for high-variation medical conditions used in the Salem hospital market were applied statewide, the annual savings would be over $47 million—more than enough to fund the entire Health Services Commission priority list when added to the rest of the funds in Oregon’s traditional Medicaid program budget. When we discuss savings of this magnitude, however, which depend on reducing hospital utilization for certain medical conditions, two questions immediately arise: first, will there be any adverse effect on patient care from reducing the use of inpatient services; and second, even if we could demonstrate that quality of care would not be compromised, how do we determine the appropriate utilization rate?

To address these questions we need only look at the conditions for which these hospitalizations are taking place. Researchers at MediQual (California) have shown that the vast majority of hospitalizations are, in fact, for “uncomplicated” patients whose treatment is likely to be successful. This research has demonstrated that 80 percent of admissions accounting for 65 percent of costs were for conditions which had less than a 1 percent likelihood of an adverse outcome—in other words, for
“uncomplicated” patients. Furthermore, most of these conditions fall into the high-variation category for which there is no firm consensus on the need for hospitalization, resulting in wide variations in hospital utilization rate from one hospital market to another. Tremendous resources could be saved through the elimination of the unnecessary hospitalization for many of these “uncomplicated” patients.

The problem lies in determining the appropriate utilization rate at which truly unnecessary or inappropriate hospital use has been squeezed out while still maintaining a high quality of care. To do so, we must develop a consensus on the appropriate treatment of the “uncomplicated” patient. The Oregon Medical Association has initiated a process to do just that. And it is hoped that over the next 18 months, we will be able to put in place a strategy which will begin to reduce the variation in practice patterns, potentially freeing millions of dollars within the health care system itself by reducing inappropriate and unnecessary care.

**Liability Reform**

Section 10 of Senate Bill 27 attempts to establish a statutory distinction between medical malpractice (which should always be litigated) and not providing services based on a consideration of effectiveness. This section requires additional work in the future and must be more clearly developed and expanded to provide indemnification for any practice patterns that may be developed.

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Appendix A1

The Commission ranked 709 condition/treatment pairs under 17 categories of care. The condition/treatment pairs in “Category 1” generally will precede those in “Category 2” and so on down the list, although Commissioners did move some pairs up or down the list independent of their categories.

Commissioners then made recommendations to the Legislature of what general categories should be covered in its Standard Benefit Package. Generally, services in categories 1-9 are considered “essential” and should be covered. Services in Categories 10-13 are considered “very important” and should be funded to the extent possible. Services in Categories 14-17 are considered “valuable to certain individuals but significantly less likely to be cost-effective or to produce long-term gain.”

Every person is entitled to services necessary for a diagnosis.

**Essential**

1. **Acute Fatal Conditions where treatment prevents death with full recovery**: such as an appendectomy for acute appendicitis, repair of a deep, open wound in the neck, non-surgical treatment for infection of the heart muscle
2. **Maternity Care including most newborn disorders**: care from conception through the first 28 days of life (prenatal, perinatal and postpartum care)
3. **Acute Fatal conditions where treatment prevents death without full recovery**: includes treatment for stroke, severe head injuries, all treatment for burns
4. **Preventive Care for Children**: immunization and well-child care
5. **Chronic Fatal Conditions where treatment improves life span and quality of life**: includes treatment of diabetes; treatable cancer of the uterus; asthma; drug therapy for HIV disease, and certain liver transplants
6. **Reproductive Services excluding maternity and infertility services**: includes birth control and sterilization
7. **Comfort Care**: pain management and hospice care for terminally ill
8. **Preventive Dental Care, adults and children**: exams; cleaning and fluoride treatment
9. **Proven Effective Preventive Care for Adults**: mammograms; blood pressure screening; Pap smears

**Very Important**

10. **Acute Nonfatal, treatment causes return to previous health**: non-surgical treatment for acute thyroiditis; medical treatment for vaginitis; filling for cavities
11. **Chronic Nonfatal, one-time treatment improves quality of life**: hip replacement; corneal transplants for cataracts; rheumatic fever
12. **Acute Nonfatal, treatment without return to previous health**: relocation of dislocated elbow; repair or cut to cornea
13. **Chronic Nonfatal, repetitive treatment improves quality of life**: non-surgical treatment of rheumatoid arthritis; gout; migraine headaches

**Valuable to Certain Individuals**

14. **Acute Nonfatal, treatment speeds recovery**: medical treatment for viral sore throat; diaper rash
15. **Infertility Services**: medical treatment for infertility; in-vitro fertilization; artificial insemination
16. **Less Effective Preventive Care for Adults**: routine screening for those people not otherwise at risk, such as diabetes screening if the person is under 40 years old and not pregnant
17. **Fatal or Nonfatal, treatment causes minimal or no improvement in quality of life**: aggressive treatment for end stages of disease such as cancer and AIDS; medical treatment for non-genital viral warts

Each health service on the list is presumed to include necessary ancillary services such as hospital care, prescription drugs, and medical equipment and supplies necessary for successful treatment.

**Appendix A2**

The Standard Benefit Package creates a level of health care every Oregonian receiving Medicaid can count on. A similar package will also be available to working Oregonians through their employers.

The Standard Benefit Package:
- Covers all major diseases children contract.
- Covers all major diseases women experience, including those from physical and sexual abuse.
- Covers virtually all current Medicaid mandates, including all preventive and screenings services.
- Exceeds Medicaid by including a number of important services not currently required: dental services; hospice care; prescription drugs; most transplants; physical and occupational therapy; diagnostic and screening services for adults such as routine physicals and mammograms.
• Exceeds Medicaid by providing unlimited medically necessary hospitalization for any covered treatment.
• Ensures a current Medicaid recipient and his/her children continued health care even after that person gets a job, a nominal raise, or acquires a car.

It includes the following important, essential primary and preventive services necessary to establish and maintain good health:

Medical examination to determine diagnosis
Well-child exams
Maternity care
Preventive dental care
Newborn care
Routine physical exams
Immunizations

Every person receives a diagnosis under the Oregon Health Plan. Then the Standard Benefit Package ensures treatment for conditions such as:

Pneumonia
Ulcers
Appendicitis
Kidney stones
Broken bones
Bone marrow transplant for certain leukemias
Burns
Glaucoma
head injuries
Ear infection
Rheumatic fever
Liver transplant (children with biliary atresia)
Asthma
Spinal deformities
Diabetes
Shoulder repairs
Epilepsy
Heart bypass
Cancer such as breast, skin, stomach, other treatable cancers
AZT and treatment for opportunistic infections of HIV disease
Chest pain due to heart disease

Patients will receive necessary ancillary services such as hospital care, prescription drugs, and medical equipment and supplies necessary for the successful treatment of those conditions/treatments covered.

The Standard Benefit Package does not pay for treatments for the following:

Conditions which get better on their own, including:
dizziness
benign cyst in the eye
infectious mononucleosis
non-vaginal warts
viral hepatitis
common cold
viral sore throat
minor bump on the head

Conditions where a “home” treatment is effective, such as:
applying an ointment; resting a painful joint; drinking plenty of fluids; soft diet. Conditions include:
non-fungal diaper rash
styes
sprains
hives
food poisoning
wrestler’s ear-bruises
canker sores
dry tendon

Conditions where treatment is not generally effective or is futile, including:
surgery for some low back pain
child born with numerous cysts on the lung*
TMJ (temporomandibular joint)
aggressive/medical treatment for end-stage cancer/HIV disease*
transplants for simultaneous kidney/liver failure*
aggressive medical treatment for extremely premature babies*
severe brain injury*

*NOTE: Comfort care is provided for these conditions, (e.g. pain management and hospice care).
Cosmetic conditions such as:
- lymph gland swelling due to excess fluid
- non-toxic goiter - swollen thyroid
- removal of scars
- benign skin tumors

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Additional Information

The full priority list can be obtained by sending $5.00 to the Oregon State Senate, State Capitol, Salem, OR, 97310-1347. (503) 378-8173.

The entire Health Services Commission report, which is a rather massive although impressive document, can be obtained by sending $20.00 to the Office of Medical Assistance Programs, Writers Group, 213 Public Service Building, Salem, OR 97310. The document will be sent by United Parcel Services, so please use only street addresses.

*$60 outside the United States

Forum Speakers and Discussants—
Larry Atkins—Winthrop, Stimson, Putnam & Roberts
Stuart Butler—The Heritage Foundation
Bill Custer—EBRI
Mary Jane England—Washington Business Group on Health
Mark Gibson—Oregon Senate President’s Office
Mike Hash—House Subcommittee on Health and the Environment
Cynthia Hosay—The Segal Company
Karen Ignagni—AFL-CIO
John Immerwahr—Villanova University/The Public Agenda Foundation
Masataka Kohda—The Pension Welfare Service Public Corporation of Japan
William Link—Prudential Insurance Company of America
Dallas Salisbury—EBRI
Roger Taylor—The Wyatt Company
Josh Wiener—The Brookings Institution

Forum Participants—
Shinji Asonuma—JETRO
Paul Berger—Arnold and Porter
Harry Cain—Blue Cross and Blue Shield Association
Vicki Caldeira—Senate Subcommittee on Labor
Nancy Carlton—Merck & Company
Ann Combs—U.S. Department of Labor
Gary Ewart—Office of Senator Don Riegel
Alan Fein—Albany Medical College
Selwyn Feinstein—EBRI Fellow
John Feldtmose—A. Foster Higgins & Co., Inc.
Marlyn Field—Institute of Medicine
Molly Frantz—Office of Representative Nancy Johnson
Beth Fuchs—Congressional Research Service
Thomas Garrity—Eli Lilly and Company
Hellen Gelband—Office of Technology Assessment
John Gentleman—Union Labor Life Insurance Company
Don Harrington—AT&T
Thomas Hartland—Hartland & Co.
Vivian Hobbs—Arnold & Porter
Suzanne Horn—Metropolitan Life Insurance Company
John Iglehart—Project HOPE
Lynn Jacobs—CIGNA
Howard Johnson—Howard Johnson & Company
Diana Jost—Blue Cross and Blue Shield Association
Ryu Yubishi—The Pension Welfare Service Public Corporation
Michael Kahn—National Education Association
Masako Katsuhira—Interpreter
Lana Keelty—National Rural Electric Cooperative Assoc.
Jeff Kinchelle—House Subcommittee on Health and Long Term Care
Dan Leach—Lutheran Medical Center
Andrea Levario—U.S. Department of Health & Human Services
Michael Mahoney—Milliman & Robertson, Inc.
Donna Martin—Bell Atlantic
Michelle McDermitt—Office of Senator Thomas Daschle
Michael McGarvey—Alexander and Alexander Consulting Group
Thomas McMahon—Pacific Maritime Association
Curt Mikkelson—Morgan Guaranty Trust Company of New York
Mike Miller—Office of Representative Sander Levin
Jim Moberg—Pacific Telesis Group
Thomas Moeller—Chancellor Capital Management
Karen Moeller—Prudential Insurance Company of America
Russ Mueller—House Subcommittee on Labor-Management Relations
Chris O’Flinn—Mobil Corporation
Bill Partridge—Howard Johnson & Company
Robert Patterson—Pennsylvania Blue Shield
Ken Refert—Merill Lynch
Melvyn Rodrigues—Atlantic Richfield Company
Sylvester Schieber—The Wyatt Company
Janet Shikles—U.S General Accounting Office
David Skovron—Kwashia Lipton
Rosalyn Sterling-Scott—The Charles Drew Univ. of Health and Science
Matthew Summy—Office of Senator Jay Rockefeller
Bridgett Taylor—U.S. Department of Health and Human Services
Carl Taylor—U.S. Department of Health and Human Services
Richard Tomlinson—The Upjohn Company
Sean Tunis—Office of Technology Assessment
Michele Varnhagen—Senate Subcommittee on Labor
Ronald Walker—William M. Mercer Companies, Inc.
Paul Wallace—Howard University
Patricia Willis—U.S. Department of Labor
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EBRI's Quarterly Pension Investment Report is a quarterly report that tracks the assets of private and public pension funds, provides historical data on pension plan contributions, examines pension plan earnings and rates of return, and looks at the portfolio allocation of pension funds and cash flows.

EBRI's Washington Bulletin is a biweekly newsletter highlighting legislative and regulatory developments in employee benefit issues.

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- Integrating Pension Plans with Social Security
- Health Insurance
- Planning for Retirement
- 401(k) Cash or Deferred Arrangements
- Profit-Sharing Plans
- Group Life Insurance Plans
- Disability Income Plans
- Legal Services Plans
- Dependent Care Programs
- Retirement Plans for the Self-Employed
- HMOs and PPOs
- Evaluating an Employee Benefit Program
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