Reforming the Health Care System: The Universal Dilemma

Uwe E. Reinhardt†

This Article surveys alternative approaches by which the advanced industrialized nations seek to cope with the twin problems that health care poses everywhere: the provision of universal access to health care and the control of national spending on health care. Although approaches to these twin problems vary considerably among nations at this time, there may well be a convergence toward a common approach in the next century. Under that approach, all health care systems will be subject to top-down global budgets and will put their health care providers into “statistical fishbowls” that reveal just how effectively these providers allocate the global budgets at their disposal.

I. INTRODUCTION

The human condition surrounding the delivery of health care is the same everywhere in the world: the providers of health care seek to give their patients the maximum feasible degree of physical relief, but they also aspire to a healthy slice of the gross national product (“GNP”) as a reward for their efforts. Patients seek from health care providers the maximum feasible degree of physical relief, but, collectively, they also seek to minimize the slice of the GNP that they must cede to providers as the price for that care.

In other words, while there typically is a meeting of the minds between patients and providers on the clinical side of the health care transaction, there very often is conflict on the economic front. It has always been so, since time immemorial, and it will always be so. It is part of the human condition. Health insurance does not lessen this perennial economic conflict; it merely transfers it from the patient’s bedside to the desk of some private or public bureaucrat who is charged with guarding a collective insurance treasury.

However, health insurance does realign the parties to the economic fray. Because insurance shields patients from the cost of their medical treatments at the point of service, it tends to move them squarely into the providers’ corner when they are sick. Usually, in that corner, patients rail, with little chance of success, against the heartless bureaucrats who refuse to finance procedures. On the other hand, when patients are healthy and faced with

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mounting taxes or insurance premiums, they are typically found in the bureaucrats' corner. In that corner, patients rail against health care providers' voracious financial appetite and holler for cost controls.

In this Article, I explore how different nations approach the universal twin problems of modern health care: the provision of access to health care on equitable terms and the control of health care costs. It is true that there is a rich variety of alternative approaches to these twin problems. It is also true that virtually every developed nation is now dissatisfied with its health care system and seeks to reform it. Unfortunately, there does not seem to be a single ideal solution.

II. CONTROLLING THE TRANSFER OF GNP TO PROVIDERS

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

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

Canadians and Europeans have long since reached a broad social consensus that health care is a social good. Although their health systems exhibit distinct, national idiosyncrasies, they share an obedience to that overarching, ethical precept.

Americans have never been able to reach a similarly broad political consensus regarding the point at which they would like their health care system to sit on the ideological spectrum that is defined by these two extreme views. Instead, American health policy has meandered back and forth between the two views, in step with the ideological temper of the time. During the 1960s and 1970s, the American health care system moved toward the social good end of the spectrum. On the other hand, during the 1980s, a concerted effort was made to move the system in the opposite direction. This meandering between distinct, ethical precepts has produced contradictions between professed principles and actual practice that confuse and frustrate even the initiated in the United States.

Table 1 presents a menu of alternative approaches to financing and organizing health care. It makes explicit distinctions between the ownership of the health insurance mechanism and the production of health care. Almost all health care systems in the world fit into this grid, and most extend over more than one cell in the grid.

For example, the health systems of the United Kingdom and Sweden occupy primarily Cell A in Table 1, though private medical practices in the United Kingdom occupy Cell C. One may think of Cell A as socialized medicine in its purest sense because the production of health care is substantially owned by the government. Clearly, the health care system of the United
<table>
<thead>
<tr>
<th>PRODUCTION AND DELIVERY</th>
<th>COLLECTIVIZED (SOCIALIZED) FINANCING OF HEALTH CARE</th>
<th>DIRECT FINANCING</th>
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<tr>
<td></td>
<td>Private Health Insurance*</td>
<td>Out-of-Pocket by Patients at Point of Service</td>
</tr>
<tr>
<td></td>
<td>Government-Financed Insurance within a statutory framework</td>
<td>within an unregulated market</td>
</tr>
<tr>
<td>Purely Government-Owned</td>
<td>A</td>
<td>D</td>
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<tr>
<td>Private Not-for-Profit Entities</td>
<td>B</td>
<td>E</td>
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<tr>
<td>Private For-Profit Entities</td>
<td>C</td>
<td>F</td>
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The Canadian health system

The West German health system

The private portion of the American system

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

The Canadian health care system occupies primarily Cells A, B, and C, as does the American federal Medicare program and the federal-state Medicaid program. Systems falling into Cells A, B, and C represent government-run health insurance, not socialized medicine, because the delivery system is largely in private hands. This distinction between socialized insurance and socialized medicine is often lost on American critics of foreign health care systems.

Germany’s health care system is best described by Cells D, E, and F. Health insurance in Germany is provided by a structured system of not-for-profit sickness funds that are privately administered, albeit within a federal statute that tightly regulates their conduct.¹ This statutory health insurance system has evolved gradually over the span of 100 years and now covers eighty-eight percent of the population.² The remainder is covered by private, commercial insurers more akin to commercial insurers in the United States.³

² Reinhardt, supra note 1, at 7; Iglehart, supra note 1, at 503, 504; see also Craig R. Whitney, Paying for Health the German Way, N.Y. Times, Jan. 23, 1993, at 1, 4.
³ See Reinhardt, supra note 1, at 10-11; Iglehart, supra note 1, at 504. The private carriers in
On the other hand, Germany’s health care delivery system is a mixture of private and public, for-profit and not-for-profit, providers that is similar to the mix of providers found in the United States. In other words, the German health care system also does not represent socialized medicine, but socialized insurance.

As noted above, parts of the American health system fall squarely into Cell A. Others fall into Cells A, B, and C. Together, Cells A through C accounted for about forty-four percent of national health care spending in 1991.4 The rest of the system, its private sector, is spread from Cells G to L. As part of the impending reform of the American health care system, this private sector is likely to slide toward either Cells D, E, and F, or even toward Cells A, B, and C. The concept of “managed competition,” for example, fits into Cells D, E, and F, as would an “all-payer” system, under which multiple private insurance carriers would be subject to common fee schedules. On the other hand, if Congress legislated a single-payer system based on the Canadian model — or “Medicare For All” — the American system would rest in Cells A, B, and C.

A. The Approaches Used in Canada and Europe

As noted, Canadians and Europeans typically view health care as a social good. In these countries, it is anathema to link an individual household’s health care financing contribution to the health status of that household’s members. Health care in these countries is collectively financed, with taxes or premiums based on the individual household’s ability to pay.5 Only a small, well-to-do minority — so far, less than ten percent of the population — opts out of collective social insurance in favor of privately insured or privately financed health care.6 Nevertheless, nearly ninety percent of the population typically shares one common level of quality and amenities in health care.

Control of health care costs in these countries is exercised partly by controlling the physical capacity of the supply side. The chief instrument for this purpose is formal regional health planning.7 Planning enables policymakers to limit the number of hospital beds, big-ticket technology (such as CT scanners or lithotripters), and sometimes even the number of physicians who are issued billing numbers under these nations’ health insurance systems.

However, regulatory limits on the capacity of the health care system inev-

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5 Jeremy W. Hurst, Reforming Health Care in Seven European Nations, HEALTH AFF., Fall 1991, at 9 (reporting results of a study of recent reforms to the health care systems of seven Organization for Economic Cooperation and Development [OECD] countries: Belgium, France, Germany, Ireland, the Netherlands, Spain, and the United Kingdom).


itially create monopolies on the supply side. To make sure that these artificially created monopolies do not exploit their economic power, these countries generally couple health planning on the supply side with stiff price and budgetary controls imposed on the demand side. Sometimes, price controls alone are deemed sufficient to control overall health spending. However, where the intent of price controls has been thwarted through rapid increases in the volume of health services rendered, these countries have imposed strictly limited global budgets on the health care systems as a whole, or upon particular segments (e.g., hospitals and doctors). Canada, for example, has long compensated its hospitals through pre-set global budgets. Similarly, West Germany now operates strict, state-wide expenditure caps for all physicians who practice within a state under the nation’s Statutory Health Insurance system. The United Kingdom and the Nordic countries budget virtually their entire health systems.\(^8\)

To implement their price and budget controls, Canada and the European countries tend to structure their health insurance systems so that money flows from third-party payers to health care providers through only one or a few large money-pipes. The “money-pipe” throughput is then controlled through formal negotiations between regional or national associations of third-party payers and associations of providers. The negotiated prices in these countries are usually binding on providers, who may not bill patients for extra charges above these prices. Although France permits extra billing within limits, most of these countries perceive unrestrained extra billing as a violation of the spirit of health insurance.\(^9\)

Remarkably, and in sharp contrast with the United States, Canada and Europe typically do not look to the individual patient as an agent of cost control. Usually, there is no significant flow of money from patient to provider at the time health services are received. Instead, most of these countries provide patients with comprehensive, universal first-dollar coverage for a wide range of services, including drugs (Canada covers drugs only for the poor). France does have co-payments at the point of service for all ambulatory care and hospital care, but not for certain high-cost illnesses.\(^10\) Furthermore, many French patients have supplemental private insurance to cover any co-payments.\(^11\)

One should not assume that Canada and the European nations eclipse patients from cost control because these nations’ health policy analysts and policymakers lack the savvy of their American colleagues. American debates on health policy tend to characterize patients as “consumers” who are expected to shop around for cost-effective health care. One suspects that Canadians and Europeans are inclined to perceive patients as, for the most part, “sick persons” who should be treated as such. Table 2 suggests why that perception may be a valid one. As Table 2 illustrates, the distribution of health expenditures across a population tends to be highly skewed. In the

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\(^8\) Hurst, supra note 5, at 13-14.

\(^9\) Id. at 10.


\(^11\) Hurst, supra note 5, at 10.
TABLE 2

DISTRIBUTION OF HEALTH EXPENDITURES FOR THE U.S. POPULATION, BY MAGNITUDE OF EXPENDITURES, SELECTED YEARS, 1928-1987

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Top 1 percent</td>
<td>—</td>
<td>17%</td>
<td>26%</td>
<td>27%</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>Top 2 percent</td>
<td>—</td>
<td>—</td>
<td>35%</td>
<td>38%</td>
<td>39%</td>
<td>41%</td>
</tr>
<tr>
<td>Top 5 percent</td>
<td>52%</td>
<td>43%</td>
<td>50%</td>
<td>55%</td>
<td>55%</td>
<td>58%</td>
</tr>
<tr>
<td>Top 10 percent</td>
<td>—</td>
<td>59%</td>
<td>66%</td>
<td>70%</td>
<td>70%</td>
<td>72%</td>
</tr>
<tr>
<td>Top 30 percent</td>
<td>93%</td>
<td>—</td>
<td>88%</td>
<td>90%</td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td>Top 50 percent</td>
<td>—</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>Bottom 50 percent</td>
<td>—</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>


United States, for example, only five percent of the population accounts for about half of all national health expenditures in any given year, and ten percent account for about seventy percent. The distribution of health expenditures in other countries is apt to present a similar pattern.

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

Where price and ability to pay cannot ration health care, something else must. Usually, in Canada and Europe, that non-price rationing device is a queue for elective medical procedures. At the extreme, some high-tech medical interventions, such as renal dialysis or certain organ transplantsations, are simply unavailable to particular patients if the attending physician judges the likely benefits of intervention to be low. High-tech innovations are introduced rather cautiously in these nations, and only after intensive benefit-cost analysis. Therefore, at any given time, these nations’ health care systems are likely to lag behind that in the United States in the degree to which a new medical technology has been adopted.

Finally, the tight control on overall outlays for health care tends to preclude the often luxurious settings in which health care is dispensed to well-

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12 See Willard G. Manning et al., Health Insurance and the Demand for Medical Care, AM. ECON. REV. 251 (1987) (reporting results of the Rand Health Insurance Experiment).

13 See Dale A. Rublee, Medical Technology In Canada, Germany, and the United States, HEALTH AFF., Fall 1989, at 178, 180 ("American physicians, with a universe of modern technology at their fingertips, are the envy of the world’s physicians.").
insured patients in the United States. Atriums and gourmet dining in hospitals, or physician offices with plush carpets, are not common in Canada or Europe.

B. The Entrepreneurial American Approach

Americans have traditionally looked askance at regulation. To be sure, some regulatory controls of the supply side of health care have been attempted at various times in a number of states (e.g., through Certificate-of-Need laws). There have also been occasional flirtations with price controls (e.g., under Richard Nixon’s presidency, or in states that regulate hospital rates). For the most part, however, Americans have always viewed the supply side of their health sector as an open economic frontier in which any and all profit-seeking entrepreneurs may gain economic fortunes. Indeed, traditionally, Americans have seen the very openness of their health system to profit-seeking entrepreneurship as the main driving force that has made the American health care system, in their own eyes, the best in the world.

American physicians, for example, have always prided themselves on their status as staunch “free-enterprisers,” and have vigorously, although not entirely successfully, defended that status against inroads by third-party payers. Furthermore, as historian Rosemary Stevens has shown convincingly in *In Sickness and in Wealth: A History of the American Hospital in the Twentieth Century*, even the nation’s so-called not-for-profit hospitals have typically run their enterprises very much like businesses. Normally, they have booked profits, though they do not distribute them to outside owners.

In contrast to Canadians and Europeans, who tightly control the supply side of their health sectors, Americans have generally freely opened theirs to fortune seekers. The American belief is that the GNP transfer that health care providers can extract from the rest of society can easily be controlled through the demand side of the sector — primarily by forcing patients to behave like regular consumers.

The traditional instrument of demand-side cost control in the United States has been cost sharing by patients. As shown in Table 3, on average, American patients are not nearly as well insured as is sometimes supposed —

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17 As already noted, some states in the United States control certain segments of their health sector through formal planning—for example, through Certificates-of-Need for hospital beds or hospital-based, high-tech equipment. See supra Section II.B. These strictures, however, have generally been of limited effectiveness. Where hospitals have been prohibited from acquiring certain high-tech equipment, for example, physicians have been able to acquire and operate it in close proximity to the hospital without regulatory control.
not even considering the heyday of the Great Society — though there is a wide dispersion around this average. Some Americans have no health insurance at all, others have very shallow insurance, and some receive from their employers generous coverage that approximates the comprehensive, first-dollar coverage available to Canadians and Europeans. Typical among the latter insured are unionized workers in the Northern rust belt.

**TABLE 3**
COST SHARING BY AMERICAN PATIENTS 1987*

<table>
<thead>
<tr>
<th>Category of Expenditure</th>
<th>Mean Annual Spending Per Person With That Expense</th>
<th>Mean Percentage of Expenditure Paid Out of Pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Health Services</td>
<td>$1,804</td>
<td>24%</td>
</tr>
<tr>
<td>All inpatient services</td>
<td>$7,120</td>
<td>8%</td>
</tr>
<tr>
<td>Inpatient physician services</td>
<td>$1,976</td>
<td>16%</td>
</tr>
<tr>
<td>Ambulatory physician services</td>
<td>$470</td>
<td>26%</td>
</tr>
<tr>
<td>Ambulatory non-physician services</td>
<td>$422</td>
<td>29%</td>
</tr>
<tr>
<td>Outpatient prescribed medicines</td>
<td>$162</td>
<td>57%</td>
</tr>
<tr>
<td>Dental services</td>
<td>$295</td>
<td>56%</td>
</tr>
</tbody>
</table>

* As of 1993, this is the most recent year for which such national survey data are available.

**SOURCE:** B. HAHN & D. LEFKOWITZ, **ANNUAL EXPENSES AND SOURCES OF PAYMENT FOR HEALTH CARE SERVICES** (AGENCY FOR HEALTH CARE POLICY AND RESEARCH, PUB. NO. 93-0007, 1992) (Tables 1 to 7).

Even the relatively high degree of cost sharing by American patients, however, has not been able to contain the growth of national health care expenditures. For that reason, additional forms of demand-side controls have been implemented in recent years, namely: (1) ex-post utilization control, (2) prospective and concurrent utilization review by third-party payers (otherwise known as “managed care”), and (3) the so-called Preferred Provider Organizations (“PPOs”).

A uniquely American form of cost control, aimed more at the supply side of the health care market, is the Health Maintenance Organization (“HMO”). Basically, the HMO is an insurance contract under which a network of providers is pre-paid an annual lump sum capitation per insured in return for the obligation to furnish the insured with all medically necessary care during the contract period. The contract is designed to make providers hold their use of resources in treating patients to the medically necessary minimum. Usually, the HMO contract leads to lower hospitalization rates, other things being equal, and to relatively lower average per capita health care costs.\(^{20}\)

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\(^{18}\) As Table 2 suggests, perhaps that particular donkey is just too weak to carry much of a cost-containment load.

\(^{19}\) PPOs are networks of fee-for-service providers that have agreed to grant large, third-party payers price discounts in return for insurance contracts that steer the insured toward these “preferred” providers through specially tailored forms of cost sharing. See ANNAS ET AL., supra note 14, at 775.

backs include limiting patient choice among providers and underserving patients.

III. THE ECONOMIC FOOTPRINTS OF THESE APPROACHES

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

A. THE COST OF HEALTH CARE

Unfortunately, but perfectly predictably, the open-ended supply side of the American health care system, coupled with a financing system that looks to sick human beings (patients) as major agents of cost control, has led to perennial excess capacity in most parts of the country, and to large and rapidly growing costs. With the exception of New York City and a few states — in which capacity has been tightly controlled through health planning — the average hospital occupancy ratio in the United States is now between sixty and seventy percent.\(^{21}\) It is below fifty percent in some cities.\(^{22}\) American physicians, for their part, have long deplored a growing physician surplus.\(^{23}\)

This enormous and excess capacity comes at a stiff price. In 1992, the United States spent close to fourteen percent of its GNP on health care, up from 9.1 percent in 1980.\(^{24}\) Current forecasts project a ratio of eighteen percent for the year 2000.\(^{25}\) By contrast, none of the other industrialized nations currently spends more than ten percent of its GNP on health care, and some (the United Kingdom and Japan) spend less than seven percent.

It is fair to assert that the high cost of American health care has contributed to a major ethical problem faced by the system. So expensive has American health become that the nation’s middle-and upper-income classes now seem increasingly unwilling to share the blessings of their health care system with their millions of low-income, uninsured fellow citizens. The gentleness and kindness for which Americans had come to be known after World War II has, thus, literally been priced out of the nation’s soul. By international standards, American health policy toward the poor — particularly toward poor children — now appears rather callous.


B. The Uninsured

At this time, some thirty-seven million Americans,\textsuperscript{26} over sixty percent of them full-time employees and their dependents,\textsuperscript{27} and more than one-quarter of them children,\textsuperscript{28} have no health insurance coverage of any type. Most of these American families have incomes below $20,000 per year.\textsuperscript{29} However, for such healthy families, an individually purchased commercial insurance policy with considerable cost sharing can run as high as $4,000 per year.\textsuperscript{30} Some insurance companies have ceased to offer the policies even at these prices because they are unprofitable. If such families have chronically ill members, however, a private health insurance policy may not be available to them at all.

Such enormous gaps in health insurance coverage do not occur anywhere else in the industrialized world. As noted above, the other member nations in the Organization for Economic Cooperation and Development ("OECD") offer their citizenry universal health insurance coverage for a comprehensive set of health services and supplies, which typically includes dental care and prescription drugs (with the exception of Canada, where these items are covered only for low-income families).\textsuperscript{31}

Traditionally, the American health care system has dealt with the uninsured in the following way: for mild to semi-serious illness, care has been effectively rationed on the basis of price and ability to pay. For critically serious illness, however, care has been made available through hospital emergency rooms, which then shift the cost of such charity care (including necessary inpatient care) to paying patients, notably those insured by the business sector.

Unfortunately, in recent years, this source of charity care has begun to disappear. The profit margins of hospitals are squeezed by a combination of excess capacity and downward price pressure by both public and private sector payers. On average, an uninsured, low-income American now receives only about fifty to seventy percent of the health care that an identical, regularly insured American receives.\textsuperscript{32}

\begin{itemize}
  \item \textsuperscript{26} Glenn Kessler, \textit{Bitter Medicine: Reform Is Coming—And This Could Be Painful}, \textit{Newsday}, Apr. 11, 1993, at 11.
  \item \textsuperscript{27} BNA, \textit{Number of Uninsured Persons Increased to 36.6 Million in 1991}, \textit{Daily Labor Rep.}, Jan. 12, 1993, available in LEXIS, Nexis Library, Omni file (reporting results of the Employee Benefit Research Institute Study).
  \item \textsuperscript{29} BNA, supra note 27; see also David U. Himmelstein et al., \textit{The Vanishing Health Care Safety Net: New Data on Uninsured Americans}, 22 Int’l. J. Health Svcs. 381, 387 (1992).
  \item \textsuperscript{31} See Raiza B. Deber, \textit{Canadian Medicare: Can It Work in the United States? Will It Survive in Canada?}, 19 Am. J. L. & Med. 75, 79 (1998). For a discussion about Canada’s funding drugs for low-income families, see supra Section II.A.
  \item \textsuperscript{32} See U.S. BIPARTISAN COMM’N ON COMPREHENSIVE HEALTH CARE (THE PEPPER COMMISSION), \textit{A CALL FOR ACTION} 34-35 (1990).
\end{itemize}
C. Styles of Rationing

The myth that, unlike other nations, America does not ration health care is just that, a myth. Americans do ration health care by price and ability to pay, sometimes in rather disturbing ways.\textsuperscript{33} Nations differ from one another not in whether they ration health care — all of them do somehow and in varying degrees — but in their style of rationing and their definition of that very term.

One rationing style is to limit physical capacity and use triage, based on medical judgment and the queue, to determine the allocation of artificially scarce resources among the population.\textsuperscript{34} That style of rationing is sometimes referred to as implicit rationing. The other style is to ration explicitly by price and ability to pay.\textsuperscript{35} It is the natural by-product of the so-called “market approach” to health care.

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

Many Americans believe that health care is not currently rationed in the United States. That belief seems warranted for well-insured patients who are covered by traditional, open-ended indemnity insurance and living in areas with excess capacity. For many of these patients, there seems to be virtually no limit to the use of real resources in attempts to preserve life or gain certainty in diagnosis.

On the other hand, persons who are less well-insured, uninsured, or covered by managed-care plans (including HMOs) do occasionally experience the withholding of health care resources strictly for economic reasons. In fact, in a recent cross-national survey, some 7.5 percent of the American respondents (the equivalent of eighteen million Americans) claimed that they had been denied health care for financial reasons.\textsuperscript{36} In Canada and the United Kingdom, fewer than one percent of the survey respondents made that claim.\textsuperscript{37}

Remarkably, the defenders of the American system, who are typically also vehement detractors of all foreign health systems, generally define rationing

\textsuperscript{33} For example, “[o]ne obstetrician . . . said she doesn’t inform pregnant Medicaid patients that they are entitled to a pain killing epidural while in labor [because] Medicaid reimbursements to anesthesiologists are so low, they balk at taking her patients.” Kinsey Wilson, \textit{Nobody Likes the R-Word: Rationing of Care Is Unpopular, But It’s Happening Just the Same}, \textit{Newsday}, Apr. 22, 1993, at 25.


\textsuperscript{36} Robert J. Blendon, \textit{Views on Health Care: Public Opinion in Three Nations}, \textit{Health Aff.}, Spring 1989, at 151, 156.

\textsuperscript{37} Id.
as only the withholding of health care from people who would have been able and willing to pay for such care with their own money. It is the nightmare of the well-to-do. Apparently, denial of health care to needy, uninsured patients who are unable to pay for that care is not viewed as rationing by these commentators because they have long countenanced it. How else can one explain these commentators' warnings that health care in, for example, the Canadian model would lead to rationing of health care, as if no American were ever denied needed or wanted health care?

It seems easier to implement the implicit, supply-side rationing practiced in most other countries than to use the explicit American approach to rationing. For some reason, both physicians and patients appear to accept with greater equanimity the verdict that the necessary capacity is simply not available, rather than the verdict that available, idle capacity will not be made available because some budget has run out.\textsuperscript{38} No one likes to see monetary factors enter medical decisions quite so blatantly as explicit rationing requires, yet a nation using the market approach to health care ultimately cannot escape consideration of these factors.

D. SUMMARY OF THE ECONOMIC FOOTSTEPS

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

IV. THE CONVERGENCE OF HEALTH CARE SYSTEMS

If one wished to paint with a very broad brush the evolution of health care policy during the past four decades in the industrialized world, one might describe it as a gradual shift from expenditure-driven financing of health care to budget-driven delivery of health care.

Under expenditure-driven financing, health care providers were allowed to do for patients whatever they saw fit and send the rest of society a bill at prices that seemed "reasonable." Typically, those presented with that bill paid without reservation. If they had reservations, they paid the bill nevertheless because they lacked the countervailing power present in normal markets without third-party payment. Naturally, under this open-ended approach, the supply side of the health sector became a rich economic frontier that attracted both the genius of private entrepreneurship and its relentless search for revenues.

Technological innovation flourished under this approach as the health sector stood an old adage on its head: instead of necessity being the mother of invention, invention became the mother of necessity. Once a technological innovation was at hand, its application was quickly deemed a "medical neces-

\textsuperscript{38} In this regard, see the fascinating analysis of this facet of British health care in Henry J. Aaron & William B. Schwartz, The Painful Prescription: Rationing Hospital Care (1984).
### TABLE 4
**COMPETING OBJECTIVES IN HEALTH CARE:**
**BASIC PROTOTYPICAL SYSTEMS THAT SPAN THE SET OF ACTUAL SYSTEMS**

<table>
<thead>
<tr>
<th>Egalitarian Distribution</th>
<th>Freedom From Government Interference in Pricing and in the Practice of Medicine</th>
<th>Budgetary and Cost Control</th>
<th>Prototypical System</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>The Health Care Provider’s Dream World</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A National Health Insurance System with Fee Schedules and Other Utilization Review (e.g., Canada, West Germany)</td>
</tr>
<tr>
<td>NO</td>
<td>TRADING-OFF</td>
<td>YES</td>
<td>A Price-Competitive Market System</td>
</tr>
</tbody>
</table>

sity” as long as it promised any additional benefits at all to the patient. Benefit-cost ratios played no role in this world because the denominator of that ratio — cost — was deemed irrelevant. Indeed, even to consider cost was deemed ethically unacceptable because that consideration might lead to the “rationing” of health care, which was deemed unacceptable on its face.

Under the second approach, budget-driven health care delivery, society establishes some sort of prospective budget for health care and tells providers to do the best they can within that budget. Typically, the establishment of the overall budget has been rather arbitrary in practice, in the sense that the budget is tied to some arbitrary criterion — such as a fixed percentage of the GNP or a fixed annual growth rate. Ideally, this approach should lead policymakers to explore what additional benefits might be gained through incremental budget expansions, and to set the ultimate budget limits accordingly. In any event, however, the application of new medical technologies in this world will typically be subjected to rigorous benefit-cost analysis before payment for such technologies will be made out of the fixed budget. Merely demonstrating promised benefits is no longer sufficient and will not be accepted by those who would stand to lose from applications of novel technology within the given budget constraints.

As noted earlier, most of the industrialized world has already gone a long way toward budget-driven health care delivery, some (England and Sweden,

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40 For example, Germany’s health care spending limit is tied to the growth of workers’ salaries and wages. See John K. Iglehart, *Germany’s Health Care System*, 524 *New Eng. J. Med.*, 1750, 1751 (1991) (second of two parts).
for example) completely. The United States is the odd one out because it is only just beginning to move in that direction. For the most part, both government and private sector payers in the United States are able to figure out what they have spent on health care in any given year with only a lag of a year or so. In fact, the announcement of total national health spending in recent years has lagged behind actual spending by almost two years. The announcement is eagerly anticipated by all concerned, and the actual numbers never cease to surprise.

There seems little doubt, however, that the 1980s represented the last decade of the completely open economic health care frontier in the United States. There is wide agreement in both the public and private sectors that health spending in the United States is out of control and needs to be reigned in by means other than the free market.

Several recent health reform proposals — including the proposal put forth by President Clinton during his campaign, and one by the prestigious American College of Physicians — have called for a global national health care budget. A national board of stakeholders, somewhat akin to Germany’s Konzertierte Aktion, determines that budget. At this time, of course, the United States lacks the organizational infrastructure for setting such a budget and apportioning it to the local level. Establishing that infrastructure alone will take over half a decade.

Furthermore, there is already widespread, open hostility toward the very idea of global budgets in the United States, not only among those who define “health care spending” as “health care income.” Opponents of global budgeting in the United States offer the strategy of managed competition/managed care as an alternative. Some proponents of that approach market it as the ‘last hurrah’ of the free market, though, in fact, the approach is inherently regulatory in nature.

“Managed competition” is frequently confused with “managed care,” but these terms relate to entirely different concepts. Managed care refers to the external monitoring and co-managing of an ongoing doctor-patient relationship to ensure that the attending physician prescribes only “appropriate” interventions. The term “appropriate” excludes procedures with no proven medical benefit, but may also eventually exclude beneficial procedures with a low benefit-cost ratio.

Managed competition, on the other hand, refers to a highly structured and highly regulated framework that forces vertically integrated, income-

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42 Konzertierte Aktion, or the Concerted Action Conference, is a group that recommends the annual aggregate increases in providers’ fees and suppliers’ prices. Iglehart, supra note 40, at 1752.

seeking managed care systems to compete for patients on the basis of prepaid capitation premiums and quality; the latter is to be measured by clinical outcomes and the satisfaction of patients. In other words, the central idea is to put competing managed care systems into transparent, statistical "medico-fishbowls" that can be compared by both patients and those who pay on behalf of patients — for example, government agencies or business firms procuring health insurance coverage for their employees.

At this time, the contrast between the current Canadian/European approach to resource allocation in health care and this newly emerging American approach is stark. Canadians and Europeans still appear to believe that the best way to control overall health spending is to: (1) constrain the physical capacity of the health system, (2) control prices, and, for good measure, (3) impose something as close as possible to global monetary budgets on the entire system. Within these constraints, however, they allow doctors and their patients considerable clinical freedom. In this way, the system will tend to maximize the benefits that are wrung out of the constrained set of real and financial resources. In other words, there is considerable trust in the medical establishment’s willingness and ability to use the resources made available to it properly, without the need for day-to-day supervision. Direct comanaging of an ongoing patient-doctor relationship in the American model is still rather rare in Canada and Europe.

In contrast, the American proponents of managed competition believe that, by paying for everything that is beneficial, but denying payment for everything else, the nation can avoid setting an arbitrary global budget and will, in the end, devote the "right" percentage of GNP to health care. These proponents have considerable faith in the ability of ordinary consumers to choose wisely among the alternative cost-quality combinations that competing managed-care systems in the health care market offer. On the other hand, they have little faith in the ability or willingness of the individual physician to use scarce resources wisely in the treatment of patients; therefore, they would subject each doctor to constant statistical monitoring and hands-on supervision.

A huge health services research industry has already been busily working on constructing the statistical "fishbowls" that managed competition will require. Whether the American automobile industry will grow in the 1990s is an open question, but the growth of the health services research industry by leaps and bounds seems assured. By the end of the decade, clinical freedom — which older American physicians once knew and loved — will be all but dead. The physicians’ daily activities, their successes and failures, will become highly visible blips on sundry computer screens.

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V. CONCLUSION

And what of the twenty-first century? How will the health care systems of Canada and Europe compare with the American health care system?

It is my thesis that the current differences between the systems will vanish over time. Most likely, Americans will learn that a managed care/managed competition approach will do many wondrous things, but it will not be able to stop the medical arms race that characterizes the American health system. The proponents of managed competition probably oversell the importance of price in consumers' choices concerning health care. To be sure, price does matter much among low-income households. Nevertheless, it is a safe bet that the competing managed care systems will beckon higher-income households, not chiefly with lower premiums, but with promises of ever-new and abundant medical technology that these elevated economic classes will find irresistible. To deny the well-to-do such novel technology in the American context is very difficult. In the end, those who would be forced to deny it will seek comfortable refuge behind some larger constraint — something like a global national or regional budget. Therefore, the United States health system will eventually envelop the competing medico-fishbowls by a global national budget imposed from the top.

At the same time, however, one must wonder whether countries that could not resist McDonald's hamburgers and Apple computers will be able to resist the magnificent statistical medico-fishbowls now being manufactured all over the United States. There will continue to be top-down budgeting in these countries, but there is apt to be less faith in the ability or willingness of the delivery system to use these budgets wisely and without hands-on supervision. Would it not be nice, and eminently proper, to inquire as to exactly what the little "medico-fish" in the health system actually do with all of the dollars, francs, marks, and pounds poured into these health care systems, particularly when such information is easily retrieved and structured? Should there not be better accountability, by individual doctors and hospitals, for their spending, their clinical outcomes, and the satisfaction they achieve among patients?

Thus, it is my bet that, around the year 2005, the health care systems of Canada and Europe will also be a combination of budgets and statistical medico-fishbowls, and that there will be a brisk commerce of ideas among health services researchers and health care managers across the globe regarding the best ways to construct these medico-fishbowls, behold them, and direct the busy medico-fish within them toward desirable ends. In short, our health systems will converge substantially, bound together by the imperative to constrain the share of GNP allocated to health care, and the awesome capacity of new information technology to extract accountability, even from the hitherto impenetrable health care delivery system.