Directing Change in an Evolving Health Care System

Positive Steps Physicians Can Take Now
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INTRODUCTORY STATEMENT OF
THE AMERICAN COLLEGE OF PHYSICIANS

Two messages heard from ACP members recently are the focus of this paper: (1) dissatisfaction with managed care and (2) interest from some members in single payer financing systems. Interest in single payer financing stems both from those who see it as the best way to achieve universal coverage to health care and from those who seek an alternative to managed care. Several resolutions adopted by the ACP Board of Governors suggested the need for a study of single payer financing and analysis of issues in managed care.

In response to this interest, the College commissioned a paper from Jack A. Meyer, PhD, a distinguished health economist and policy analyst. The College asked Dr. Meyer to examine the functioning of managed care and the relevance of single payer systems to US health care. Dr. Meyer has written an outstanding paper, which the College is pleased to contribute to the ongoing health policy debate. The College endorses much, although not necessarily all, of his analysis and recommendations. Specifically, ACP supports the following findings and recommendations:

1. Adoption of any of the single payer financing models is not politically feasible and probably would not mesh with American culture and economy. However, there are lessons to be learned from other nations that may help us alleviate some of our system’s problems.

2. Managed care will be the favored approach of private and public purchasers of health care coverage for the foreseeable future. There are many models of managed care, including those utilizing fee-for-service payments, and managed care is evolving rapidly although unevenly.

3. Managed care has been carried to extremes in some areas, threatening quality of care. It has been carried to extremes because we have expected too much of it. Managed care can do little to address the major forces driving health care spending in this country.

4. The major cost drivers are growth in real income, explosion of medical technology, patient expectations, the litigation system, population aging, and risky behavior and lifestyles. These forces, in Dr. Meyer’s words, “have nothing to do with the way we pay physicians, hospitals, and other health care providers, and little to do with the way health care is managed and organized. These forces will push up spending in HMOs, PPOs, and indemnity plans alike. They will drive costs in both capitated and non-capitated financing arrangements. Thus, if all we do is tinker with payment schemes and ignore these fundamental underlying forces, we will never control health spending.”

5. Private and, increasingly, public purchasers of health care push managed care in an attempt to solve the entire health cost problem. Without strategies to address the real cost drivers, attempts to restrain health care spending are doomed to failure. Instead of attempting to increase cost-effectiveness and productivity to achieve a goal of coordinated and high quality care, managed care uses a variety of micro-management techniques, reducing the amount of care reimbursed with the goal of minimizing cost.
6. The alternative is to restrict our expectations of managed care to increasing cost-effectiveness, a goal that requires a great deal of research and information sharing and places much responsibility on physicians and other health care providers. But we will only lower our expectations of managed care if the nation commits itself to finding different solutions to the other forces driving health care spending.

7. Dr. Meyer highlights two major differences between the US and other developed nations: The first is that coverage is nearly universal in other nations, although he points out that typically they did not achieve universal coverage in one great leap, but in a series of extensions of benefits. Universal coverage avoids risk selection, cost shifting, cost avoidance, delayed care, and other problems that contribute significantly to unnecessary spending in this country.

8. The second difference is in the approach to cost control. The formula that appears to work in other nations includes: (1) a global budget, with separate sub-budgets for hospital and ambulatory care; (2) physician fee schedules; and (3) monitoring of volume levels by physician-run organizations. In France and Germany, for example, physician organizations play a significant role in negotiating fee schedules within the framework of a prospective budget and in monitoring the practice patterns of their colleagues, identifying and sanctioning outliers through payment reductions. Dr. Meyer characterizes this as a macro-management approach which relies on greater peer review rather than before-the-fact clearances of services and questioning of individual clinical decisions. In contrast, US physicians are increasingly held accountable for each medical decision to both a payer and to the legal system; outside of staff model HMOs or some new physician-directed plans (provider sponsored organizations), there is little accountability to peers.

9. Increased physician responsibility for reducing inefficiency and improving health care quality must be incorporated into the US system, as outlined in a series of actions presented under recommendation #1 in Dr. Meyer’s paper. In associating ACP with these recommendations, we recognize an explicit trade-off: In seeking increased responsibility and decreased micro-management, physicians accept that they will be subject to objective “front end” criteria, based on performance, for entry into a health plan, as well as periodic review of their practice patterns. The College does not underestimate the enormous amount of work that needs to be done to facilitate this approach, including both the development of performance standards and the authority and legal protection to conduct peer review. The action steps sketched out by Dr. Meyer under recommendation #1 constitute a strategy for preserving the market-based approach and public-private partnership that has characterized American health care with improvements, drawn from single payer systems, that enhance the role of physicians in achieving cost-effective care.

10. The College agrees that capitation can serve as a mini-global budget, as outlined in recommendation #2, creating incentives that control the unrestrained use of technology and otherwise lead to more cost effective care. Capitation can create the conditions to facilitate adoption of guidelines for appropriate care, measurement of outcomes, and performance monitoring. Capitation can be implemented in a number of ways, including at the level of purchaser (employer, government) to health plan, allowing flexibility in the way physicians and
other providers are paid. A capitation approach allows for local variation and control, although it is less certain to restrain the overall rate of increase in health spending. In a sense, it can serve as a series of demonstration projects for prospective budgeting. Capitation requires safeguards so that under-utilization does not jeopardize patient health; physicians have a major role to play in developing and implementing those safeguards.

11. Recommendations #3-7 by Dr. Meyer touch briefly and without detail on other areas that require reform, including those forces identified earlier as driving spending increases. The American College of Physicians has existing policy in many of these areas. For example:

- **Malpractice reform**: Tort reforms are necessary to stabilize the system, but new approaches must be explored, including modification of the Employee Retirement Income Security Act (ERISA), which courts have ruled protects managed care organizations from liability, and enterprise liability that reflects the growing complexity of health care delivery.
- **Physician workforce**: Better balance is necessary between generalists and subspecialists. The number of residency slots must be brought in line with projected need. Continuing support for education and research is essential through all-payer funding.
- **Technology**: Aggressive steps are necessary to assure that new technologies are proven effective before their widespread adoption and to minimize overlapping of facilities and services in a community. The nation continues to grossly underfund research on cost effectiveness and health outcomes.
- **Access to care**: The College has renewed its call for universal coverage. Access should be expanded incrementally until all Americans are covered, using public and private mechanisms. The College has opposed budget cuts or other proposals that would increase the numbers of uninsured.

The US health care system is evolving in uniquely American ways. Managed care has produced serious dislocations for patients and health care providers, but managed care approaches have won the support of private and public purchasers of care. The challenge for physicians is to accept responsibility for patient care that is both cost-effective and reflects standards of excellence. Some of the lessons learned from other nations may help the profession meet that challenge.

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DIRECTING CHANGE IN AN EVOLVING HEALTH CARE SYSTEM:

Positive Steps Physicians Can Take Now

Paper Prepared for:
The American College of Physicians

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New Directions for Policy

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NEW DIRECTIONS FOR POLICY (NDP)

NDP is a Washington-based firm that assists business, purchasers and providers of health care, and government through policy research and analysis, strategic planning, and program evaluation. NDP’s purposes are to promote more effective operation of the health care system, and to aid the development of sound public policy on health care and welfare reform issues. NDP analyzes the forces driving health care spending, designs innovative strategies to improve financing and delivery systems, and evaluates major reform proposals. NDP also develops new policies to reduce unemployment and improve the social welfare system.

Jack A. Meyer, Ph.D., is President of New Directions for Policy. He is a health economist who has written widely and conducted extensive policy analysis in the area of health system reform. He is the author of numerous books, monographs, and articles on topics including health care, labor market and demographic trends, and policies to reduce poverty. Dr. Meyer is also President of the Economic and Social Research Institute, a non-profit research organization in Washington, D.C.

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5. Address the major cost drivers in the health care system.  
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I. INTRODUCTION

The purpose of this paper is to develop an agenda for changing our health care system to help meet basic goals related to cost, quality, and access. Special emphasis will be placed on the appropriate role of physicians in pursuing these goals.

One premise is that despite some notable successes, we are veering off course in our effort to achieve our basic objectives. Another premise is that we can learn some valuable lessons from other countries without actually adopting their health care systems.

The basic goals for our system include the following:

- achieving clinical excellence to bring patients the best care possible
- making the system cost-effective to conserve scarce resources
- maintaining clinical decision-making by physicians and patients
- protecting the rights of patients without excessive litigation.

These goals, taken together, challenge us to combine the pursuit of quality improvements and access to care with cost discipline. Often, these goals will conflict, and force us to confront difficult tradeoffs. Other countries face these same tradeoffs, and we can learn from their efforts to balance the fundamental goals in health policy while maintaining the basic characteristics of our own system.

Countries with similar health care delivery systems have very different financing systems, and vice versa. A decision to use an adapted form of one country's financing system would not compel the use of its delivery system. One component of a country's cost control apparatus could be adapted for use in the U.S. without importing other components. Within certain limits, we can "mix and match" components of health care systems. The key point is that we do not have to choose between pure forms of one type of system and pure forms of another. A variety of "alloys" are available, each with different strengths and weaknesses.

This paper also starts with certain judgments about the boundaries within which health care policy will be shaped in this country for at least the near future. Clearly, the desire to
constrain the growth of health care costs will continue to have overriding importance. In
general terms, there are two major approaches to limiting costs. One is to rely heavily on
government to do the job. The other is to employ market forces to impose cost discipline.
Perhaps the purest form of the governmental approach to cost control is something like a
single-payer system, where the basic constraint is a government budget. This paper reflects
the judgment that any variant of a single payer system is simply not politically viable at
this point in the country's political history. Regardless of its merits or deficiencies, reform
as sweeping as a single-payer system is, at this time, unable to garner sufficient support
from the American people and their political representatives to become law.

On the market side, those who are leading the struggle to contain costs, especially
employers, are strongly committed to implementation of managed care systems as the
primary vehicle for imposing cost control. For better or for worse, the fact is that the
movement to deliver health care through managed care systems has such headway that it
cannot be stopped. To simply take a hard and fast stand in opposition to managed care
would be fruitless, especially when no viable alternative is on the horizon. The people who
pay the health care bills, especially the nation's employers but also government payers,
would reject this position out of hand as irresponsible and unrealistic.

The conclusion, which informs the analysis of this paper, is that for at least the next few
years, managed care will represent the major approach to cost containment. Thus the
challenge for physicians, and others, is to structure managed care in a way that will
achieve efficiencies but not at the cost of undermining the quality of patient care or
destroying clinical decision-making by physicians and patients.

A major thrust of this paper is to demonstrate that, while the movement to manage care is
a natural evolution of our health care system and our economy, managed care is being
carried to extremes that threaten the key goals outlined above. Even if it were politically
erdible, an appropriate response would not be to turn back the clock and return to the
days when passive bill payers simply underwrote prevailing practices and asked few
questions. Instead, we need to ascertain how to make mid-course corrections in managed
care to tame its excesses while capturing its many benefits.

Another theme of the paper is that access problems are very serious in the U.S., and may
get worse in the future unless corrective actions are taken. This study underscores the need
to move toward universal coverage and improved access to health services.
Section II of the paper presents the basic trends in the U.S. health care system and highlights the emerging problems and challenges. Section III explains how other countries approach these challenges, and tries to distinguish facts from rhetoric and slogans. Section IV presents recommendations, reflecting lessons learned from abroad that can help us achieve our goals.
II. THE U.S. HEALTH CARE SYSTEM IS VEERING OFF COURSE

The U.S. health care system is not fully achieving the basic goals presented above. First, we are not making a serious effort to assure access to care for everyone, and in fact, seem to be moving further away from this objective. Second, we are relying on managed care strategies that both interfere with clinical decision-making and the physician-patient relationship and hamper efforts to achieve clinical excellence. Third, the medical malpractice system is driving up costs while not adequately protecting patients who really need help.

The overall health care system is making some early progress toward improving the cost-effectiveness of health care. But this movement requires much more development, and the payoff is uncertain.

**Trends in Access to Care**

The number of uninsured has been edging up gradually. In 1996 an estimated 39 million people, or 16.8 percent of the nonelderly population, can be expected to be without health insurance (Blumberg and Liska 1996). Recent projections indicated that the number of people without coverage is expected to grow to 49-67 million by 2002, and could exceed 67 million if states are forced to remove some people now receiving Medicaid from eligibility (Thorpe 1995). This is not an unrealistic possibility in light of the potential federal budget legislation that would tightly constrain the growth in federal outlays for Medicaid. Indeed, while prior reform proposals sought universal coverage, current reform proposals could leave more and more people without coverage.

The U.S. has been making some progress, in small increments, toward covering more of its neediest residents. In 1990, Congress enacted a plan to provide Medicaid coverage, in stages, to all children in families below the federal poverty line, irrespective of eligibility for cash assistance. In the first year, this requirement extended to children under six years of age, and is scheduled to rise by one year every year until 2002, when all youth up to age 18 would be covered. In 1996, the guarantee extends to children up to age 12. Proposals by both the Congressional Republican leadership and the National Governors Association, however, would halt this incremental expansion, leaving poor teenagers vulnerable. Unfortunately, the Medicaid expansion to date, which also includes assuring coverage to
pregnant women with incomes up to 133 percent of the poverty line, has been offset by reductions in private coverage, with the result that the total number of people without coverage has increased in recent years.

Underinsurance is also a problem. An estimated 29 million Americans — or nearly one of five people with private insurance — were at risk of spending more than 10 percent of their family incomes on out-of-pocket health expenditures (Short and Banthin 1995). Access problems, of course, go beyond the gaps in insurance coverage. Barriers to care emerge from transportation problems, language difficulties, discrimination, and a lack of education. Neighborhood health centers face inadequate funding and growing demand for their services. Many are left behind in the growing trend toward managed care systems. Insufficient funding for loans and scholarships to physicians who commit to serve in inner-city and rural areas heighten the problem. Many public hospitals are in a dire fiscal situation, overwhelmed by the need to provide uncompensated care to indigent patients and by cutbacks in public programs. And those who pay for health care are less willing to cross-subsidize non-paying patients in today’s competitive environment.

In addition, risk-selection continues to plague our health care system. Although managed care organizations typically do not refuse certain customers, they use subtle techniques to “cream-skim,” marketing to relatively healthier people and sidestepping those with disabling conditions and high-risk factors. Health coverage has generally not been “portable,” leaving people vulnerable to losing coverage when they lose a job or change jobs. This particular problem will be greatly alleviated by legislation enacted by Congress in August 1996.

All of these trends translate into a combination of rising numbers of uninsured and underinsured patients and an inadequate “free care” system. This is neither a humane nor a sustainable situation.

**The Movement to Managed Care**

The movement to managed care can help correct flaws in the traditional health care delivery and finance system in the U.S. These flaws involve incentives toward excessive care that inflate costs and, in some cases, can endanger patient health. To take one example, unnecessarily long hospital stays were shown in one study to result in increased risk of nosocomial bloodstream infections. These infections added 14 more days to hospital
stays among infected patients in a surgical intensive care unit, and $40,000 to cost per survivor. Patients who contract such infections had a death rate of 50 percent, compared to 15 percent for those who did not get infections. (Pittet, et al. 1994).

Another example involves the poorly coordinated use of medications, as well as patient noncompliance, particularly by the elderly, which can result in adverse health outcomes. Rates of noncompliance with medication regimens have been estimated at 40 percent for hypertension, 40-50 percent for diabetes, and 55-71 percent for arthritis (Smith and Levy 1994). The inappropriate use of emergency rooms has driven up costs, particularly in the Medicaid program (Hurley, Freund, and Paul 1993).

Managed care can improve all of these situations. It holds the potential to better coordinate health care services, to integrate care with social services, to reduce inappropriate treatment, and to foster the delivery of care in the least restrictive settings for patients, which both reduces costs and improves quality.

Although the term managed care is often used loosely to encompass a very broad range of activities and mechanisms, at least in theory, it should include the following elements: 1) someone has responsibility for coordinating the whole range of medical services a patient receives; 2) medical resource allocation decisions are to be guided by standards and protocols about what constitutes appropriate care and are subject to external review and monitoring.

Thus, this is not a paper about the inherent defects of managed care. Instead, this paper makes two different arguments: 1) we are expecting too much of managed care; and 2) the way we are implementing it is interfering unnecessarily with physician autonomy and clinical decision-making. Furthermore, these two problems are interrelated. Because we are expecting too much of managed care, we are implementing it in a heavy-handed way that gives cost control far too much prominence and the search for good quality short shrift.

An estimated 51 million Americans were enrolled in Health Maintenance Organizations (HMOs) in 1994, and another 46 million were enrolled in PPOs (GHAA 1995). Medicaid programs are rapidly shifting beneficiaries into managed care, often in a mandatory fashion. While enrollment in managed care is limited in Medicare (9 percent of beneficiaries were in HMOs in 1994), it is growing at a more rapid pace than in the private sector.
The issue is what we will get out of all this shifting in enrollment. What does it mean for cost control?

**The Forces Driving Health Care Spending**

The U.S. is expecting too much of managed care because of a failure to recognize the comparative importance of the fundamental and powerful forces driving up health care spending. Some of the most important cost drivers do not involve the way our health care financing system operates.

First, the growth in real income in the U.S. has been shown to be a very significant force in driving health care spending. In the U.S. and other countries as well, growth in health care spending seems to be tied to growth in income, apparently reflecting the fact that people place high value on the perceived benefits of consumption of health services. According to one study, two-thirds of the 3.8 percent annual rise in per capita health spending in the U.S. over a period of six decades is accounted for by the growth in national income (Getzen 1990).

Second, the explosion in medical technology is an important force pushing up health care outlays. According to Dr. William Schwartz, new technology explains one-fourth of the growth in hospital spending (Schwartz 1987). Of course, this technology translates into not only longer life expectancy, but also an improved quality of life. Hip replacements, pacemakers, cataract surgery, and many other procedures improve people's quality of life — but such enjoyment must be purchased with dollars that have alternative uses. A key problem is that technology, which in its initial design seems cost-effective, is then often applied more broadly to include more questionable uses. In these situations, the expected benefits are relatively low and the costs are high.

Thus, two of the major cost drivers — our increasing standard of living and the new technology that our wealth enables us to buy — are at the heart of rising outlays for health care, and these forces represent developments that generally reflect our preference as a society.

A third force is consumer expectations, which interact with research and technology. Americans are not inclined to queue up patiently for health care. They often want direct access to the most advanced medical treatment, sometimes in cases where such treatment is
very costly and the likelihood of success is quite remote. If the costs of new technology are to be restrained, this needs to occur in advance of its application and availability. Once the technology becomes available, it is difficult to restrain its use.

These key cost drivers — growing incomes, technology, and patient expectations — are shaped by forces that are largely external to managed care, and this highlights the danger of relying solely on managed care to address the issue of how to restrain the increase in health care spending.

The U.S. litigation system reinforces the tendency for delivering high-cost care with marginal medical benefits, as providers are wary of withholding any care with even the most remote chance of extending life (almost irrespective of the quality of that life). Liability claims have risen dramatically in the last 25 years, and the concerns of medical practitioners have risen in response to this trend. Before the 1960s, only one physician in seven had ever been sued in his/her lifetime. Today, about one physician in seven is sued per year (Bovbjerg 1995).

Population aging has been a minor force in the health care spending picture in the past (Getzen 1992). But it is likely to be a powerful driver in the next century when the large cohort of baby boomers retires. Longer life expectancy, of course, also reflect successful advances in medicine. But with such success comes the need for long-term care for chronic illness and disability, along with greater needs for acute care. Finding ways to deliver long-term care in settings that are the least restrictive for patients, and at an affordable cost, poses a huge challenge for the future. The number of people requiring nursing homes is expected to rise from about 1.8 million to at least 4.3 million in 2030 (Zedlewski et al. 1990). The costs associated with nursing home care are enormous.

Risky behavior and lifestyles are also pushing up health care spending. Smoking, crime-related violence, drug and alcohol abuse, and unsafe automobile driving are the most obvious examples of behaviors that pile up health care spending. Poor diets and a lack of exercise are also at work in increasing the risks associated with heart disease and other medical problems. According to a study by J. Michael McGinnis and William H. Foege, about one-half of all deaths that occurred among U.S. residents in 1990 could be attributed to factors related to behavior and lifestyle. Tobacco use alone contributed to 400,000 deaths while another 100,000 were related to the misuse of alcohol products (McGinnis and Foege 1993). Prior to these deaths, considerable health care resources were expended
in the care of these individuals. Of course, it can be argued that premature deaths do not so much “cost” the system money as accelerate the spending for health care that would be incurred by such people in later years. Nevertheless, we are spending a lot of money as a result of paying insufficient attention to modifying human behavior and failing to capitalize on cost-effective investments in several types of preventive care services (Meyer and Regenstein 1994).

*It is important to note that the six major spending drivers just enumerated have nothing to do with the way we pay physicians, hospitals, and other health care providers, and little to do with the way health care is managed and organized. These forces will push up spending in HMOs, PPOs, and indemnity plans alike. They will drive costs in both capitated and non-capitated financing arrangements. Thus, if all we do is tinker with payment schemes and ignore these fundamental underlying forces, we will never control health spending.*

**Poor Incentives and Unmanaged Care**

Of course, this is not to suggest that our health care payment and delivery systems are fine — flaws in these systems are an important part of the problem. Incentives for both consumers to want more and more health services and for physicians to order more and more health services have exacerbated the health spending problem. Open-ended federal tax subsidies have encouraged workers to load up on comprehensive insurance that has insulated them from the costs of care. Incentives for physicians to conduct more tests and perform more procedures have been embedded in traditional fee-for-service payment arrangements. Health care services are not always properly coordinated; there is a bias in our payment policies that favors institutional care over care at home; and we have under-invested in preventive and primary care.

**Excessive Reliance on Managed Care**

The challenge facing the U.S. system is this: since “unmanaged care” is only one of several cost drivers — and probably not among the most powerful — employers, government, insurers, and managed care organizations (MCOs), with few palatable options beyond managed care on their planning horizons, are driven to take managed care to great extremes in a (probably vain) attempt to use this one lever to solve the entire health cost problem. We are acting as if the whole problem were one of faulty incentives and the
behavior of consumers and providers. This is a problem, but because it is only one part of the problem, we will be increasingly frustrated if we largely ignore the other forces and keep tightening the vice on the system through ever-more stringent managed care limits. At some point, we will pass the stage of diminishing returns and reach the point of negative returns.

Managed care enthusiasts respond that when incentives are improved, forces will be unleashed that yield continuous improvements in cost and quality. There is some limited evidence that growing HMO penetration reduces the rate of growth in hospital costs (Gaskin and Hadley 1995) and brings down costs in the fee-for-service system (Rogers and Smith; Baker 1995). Other studies suggest that while at least certain forms of HMOs clearly reduce utilization, there is not enough evidence to determine if they hold down the rate of growth in total spending (Miller and Luft 1994). A thorough review of the literature on HMO performance states that "There are not many results for most dimensions of performance, and there are few or no results for key summary measures of performance, including total health plan system-level expenditures, out-of-pocket costs per enrollee, and the level and rate of growth of premiums (Miller and Luft 1994)."

Nominal health care spending increases have decelerated in recent years. But this reflects, in part, a dramatic slowdown in general inflation; real health care spending increases remain in line with the trend of the last three decades. Moreover, there are short-term gains from the massive shifts of consumers into managed care organizations — gains that may not be repeated. A recent forecast published in the HCFA Review shows that real spending increases in the health care sector will average 2.4 percent per year over the 1993-2005 period, about the same as the corresponding rate (2.5 percent) over the 1983-1993 period (Burner and Waldo 1995).

Thus, as we review the U.S. health care system against the backdrop of foreign systems, we will ask what we can learn from these systems about how to address all the cost drivers in our system, not just those involving payment system inefficiencies.

At some point, we will exhaust the benefits from relying so heavily on external review of physician decisions by managed care organizations. Similarly, we will also recognize that such external control brings costs as well as benefits.
Managed Care as "Micro-Management"

The way the bill payers in the system — employers, unions, Medicare and Medicaid, and private insurers — are implementing managed care often causes conflicts with basic policy goals. Specifically, bill payers too frequently "micro-manage" patient care. This involves insurance company employees who are not clinicians second-guessing many of the decisions that physicians and patients make. While the rhetoric of managed care stresses early intervention and service coordination, the reality often involves requirements for doctors and patients to get the approval of managed care personnel no matter how defensible a medical decision and the use of gatekeeping that sometimes inappropriately blocks or delays patients from using the health care system. Physicians spend considerable time on paperwork.

A badly implemented managed care strategy does not yield a more cost-effective system — the goal presented here. Instead, it represents a cost minimization objective, which is very different. We need to improve the productivity of the health care system. This requires getting the best patient outcomes per dollar invested, and requires careful research to determine when medical services are both medically effective and cost-effective. In actual practice, such criteria are not in wide use today.

As noted earlier, managed care plans' initiatives to stress preventive care, to coordinate services, and to provide care in home and community-based settings can improve patient satisfaction and health outcomes. But there is also a dark side to the managed care movement. First, managed care plans, under relentless pressure from employer purchasers, are sometimes inappropriately reducing the amount of care they will reimburse, often with more concern about reducing costs than improving quality (despite the rhetoric of continuous quality improvement).

The pressure to get new mothers out of the hospital is an example of a good idea that may have been carried too far. Up to a point, length of stay for maternity cases could be reduced without risk to mothers and their newborns. But as the length of stay that health plans would pay for fell to 24 hours, the incidence of some dangerous health outcomes for newborns began to increase. Many cardiopulmonary complications become apparent during the first 12 hours after birth. Other medical problems, however, such as jaundice, ductile dependent cardiac lesions, and gastrointestinal obstruction, may require a longer period of observation by skilled and experienced medical personnel. Also, length of stay
should take into account the unique characteristics of each mother and newborn, including such factors as the overall health of the mother, a support system at home, and access to appropriate follow-up care (American Academy of Pediatrics 1995). To arrest this trend toward ever-shorter stays for maternity, Georgia, Maryland, Massachusetts, New Jersey, New Mexico, and North Carolina enacted legislation by installing 48-hour minimum stays. By mid-1996, similar legislation was pending in 22 other states.

Generally speaking, it is not a good idea for government to legislate specific standards of medical care. In this case, legislation emerged because payment standards seemed to pose a health risk, and the physician community was falling in line with health plan standards. A preferable outcome would have been for physicians to have been more involved in setting reimbursement standards in the first place, infusing their understanding of both the benefits and risks of shorter hospital stays into managed care policies.

Another example involves MCOs’ requirements that patients obtain authorization from gatekeepers before using emergency rooms, except in life-threatening situations. Some health plans are denying payment if the diagnosis turns out not to be life-threatening even though the presenting symptoms appeared to be life-threatening.

While there is much talk about efficiencies and “total quality management,” in reality, a lot of the activities of some managed care organizations involve simply driving down both fees and utilization. Lower fees are deemed to be an improvement over higher fees. A three-day stay in a hospital is better than four. Two days are better than three. Outpatient surgery is better than inpatient. Another way that MCOs make money is by gatekeeping. Administrative staff run through a pre-set checklist to determine if the patient needs to see a physician. A primary care physician determines if the patient needs to see a specialist. Some managed care organizations determine a fixed number of therapy or psychological counseling sessions that a patient needs, and that’s all that they will pay for.

Another example of MCO practices that can be dangerous to patients’ health involve so-called “gag clauses.” These contractual clauses restrict the content of physicians’ medical counseling through such methods as refusing to allow physicians to inform patients about treatment options available outside a health plan’s network.

It is true that many of these developments were spawned by evidence of excessive utilization — unnecessary surgery, the over-use of diagnostic tests, inappropriate self-referrals to specialists.
But the reality is this: because purchasers have come to be so heavily dependent on managed care to control costs, they are using it relentlessly to drive down fees and service use. Increasingly, physicians are either employees of corporate entities or involved in contractual relationships. In either case, their ability to earn a living will hinge on their demonstrated ability to reduce providers’ fees and the use of health care services. Because physicians are in excess supply in many parts of the country, they are in no position to argue; if they do not play by the rules of managed care, they will be quickly replaced by those who do.

Of course, as discussed below, in some cases, utilization norms are determined through careful research that blends medical outcomes and cost into measures of value or cost-effectiveness. This is the way appropriate use should be determined. But in today’s world, melding cost and quality is honored more in rhetoric than in practice. Too often, purchasers simply “buy cheap” — mainly by searching for discounts off billed charges.

A Better Approach

A better approach to managing care and making our system more cost-effective can be seen in efforts by private employers and MCOs to measure provider performance and use this information to contract selectively with physicians and hospitals. Employers, acting on their own and through local business coalitions, are working with providers to develop comparative measures of health outcomes along with patient satisfaction indicators. In some cases, employers are building this information into a “request for proposals” on which health plans and provider care systems can bid.

For example, in Minneapolis-St. Paul, the Buyers Health Care Action Group built quality indicators into an RFP and selected HealthPartners, an integrated network combining an HMO, a hospital system, and the Mayo Clinic, to provide services to the employees of 23 member companies over the 1993-96 period. The Institute for Clinical Systems Integration in the Twin Cities represents a joint effort of physicians and employers to develop specific practice guidelines, to evaluate new medical technology, and to train professionals to incorporate best medical practices. In addition, the Health Data Institute in the Twin Cities is working to create a seamless electronic interchange of claims information across payers and providers, and ultimately a repository of information that can be used to analyze provider practice patterns, costs, and health outcomes (Meyer et. al. 1996)
In New England, GTE, Digital, and Xerox conducted an in-depth patient satisfaction survey and combined patients' ratings of health plans with objective scores determined from generally accepted indicators of quality to form a composite rating of health plans. They are using this information to help determine which plans to offer employees (Meyer 1995).

Research at Inter-Mountain Health Care in Utah led to new approaches about determining the precise time to begin administering antibiotics prior to surgery in order to reduce post-operative wound infections. This work cut the infection rate in half.

There has also been extensive research documenting large variations in practice patterns. Medical journals have reported findings of huge variations in costs and practice patterns across regions and among physicians. For example, coronary angiography rates per 10,000 people among Medicare enrollees in 23 adjacent counties ranged from 13 to 158; the corresponding range for carotid endarterectomy was 5 to 41 per 10,000; and 42 to 164 for upper gastrointestinal tract endoscopy (Leape 1990).

The public sector is also active in collecting and analyzing information. The Agency for Health Care Policy and Research is leading federal efforts to develop protocols for specific medical services. State data commissions are building data bases measuring costs and outcomes by provider, and making such information public. Pennsylvania's Health Care Cost Containment Council has published information comparing hospital charges and performance, along with comparisons of individual surgeons. Since proprietary interests of MCOs often stifle collaboration, the public sector needs to make a substantial investment in guidelines development and outcomes research.

Physicians have been very active in developing clinical practice guidelines, working mostly through clinical societies. The American College of Physicians has been a leader in this field through the Clinical Efficacy Assessment Program (CEAP). Much of the foundation for guidelines is the clinical literature, and much of the research that underlies that literature is assisted by NIH-supported biomedical research.

These efforts stand in stark contrast to simply placing roadblocks on consumers' use of the system. The quest for standards of appropriate care, based on careful research, is superior to the process of denying care and micromanaging the use of the system by both physicians and patients. The challenge for the U.S. is to build up the former and substitute it for the latter.
Provider Responses to Changing Payment Policies

The provider side of the health care market has responded to buyer pressures through a wave of mergers, acquisitions, and systems integrations. Hospitals are merging; investor-owned hospital chains are acquiring nonprofit hospitals; hospitals are forming contractual relationships with primary care physician groups and marketing to customers based on their ability to control referrals to specialists, diagnostic testing, surgery, etc. Several pharmaceutical companies have purchased pharmacy benefit management companies (PBMs) that help employers control drug costs.

Solo physician practices are rapidly giving way to group practices. Self-employed physicians in solo or two-partner practices fell from over 50 percent in 1987 to 37 percent in 1993 (PPRC 1995). Small, single-specialty group practices are giving way to large, multi-specialty groups. Many physicians are selling their practices to hospitals and becoming employees. The proportion of U.S. physicians who are employees rose from 36 percent to 39 percent between 1993 and 1994 (AMA Socioeconomic Monetary System 1994). Physicians are also forming entities such as Group Practices Without Walls, where a group practice adds individual physicians to an entity that shares administrative expenses and negotiates contracts, and Physician Organizations (POs) that put special emphasis on utilization management, quality assurance, and primary and preventive care.

In addition to physicians joining forces with other physicians, they are also forming networks with other providers. These include Physician Hospital Organizations (PHOs), Management Service Organizations (MSOs), and physician-run HMOs.

The pressure from bill payers appears to be reflected in the trend in physicians' earnings. Adjusted for inflation, physicians' earnings have been flat for several years. Moreover, physicians' net income declined in 1994 for the first time since the AMA began collecting data. Physicians as a group earned an average of $150,000 in 1994, down 3.8 percent from 1993. Earnings varied significantly by specialty. For example, family practice physicians earned $110,000 on average, in 1994, while surgeons averaged $219,000 and radiologists earned $220,000. Employed physicians averaged $130,000 while self-employed physicians averaged $176,000 (AMA Socioeconomic Monetary System 1994 and 1995).

Some portion of the gains from reduced provider income has been realized by employers and employees, and some portion by federal, state, and local governments. But the
managed care industry also takes a chunk. For example, unweighted data from Colorado show that claims paid out for HMOs average about 81 percent of premiums for not-for-profit HMOs and 79 percent for-profit HMOs. The remainder is accounted for by administration and profits. Among for-profit companies, the claims ratio ranged from 70.4 percent to 91.9 percent (Baumgarten 1994).

A study prepared by the California Medical Association showed that in fiscal year 1994-95 there were very large differences among health plans in the proportion of health care premium and investment dollars accounted for by administrative costs and profits. The sum of administrative costs and profits ranged from 3.2 percent to 27.2 percent. Administrative costs alone ranged from a low of 2.1 percent to a high of 30.0 percent (California Medical Association 1996).

Physicians and hospitals are forming organizations designed to respond to the concern over high administrative costs, as well as concern over chronically ill populations that are “de-selected” by the managed care/insurance industry. Physician-sponsored coordinated care organizations are designed to emphasize the intrinsic value of physician-patient relationships while reducing a layer of profit and overhead incurred under current managed care and insurance company delivery systems.

Frustration over the “leakage” in the gains from decelerating health care costs to “middlemen” is also leading some employer purchasing groups to bypass MCOs and contract directly with providers. In Des Moines, Iowa, for example, Community Health Purchasing, Inc., a group of employers, has designed an RFP for health care systems and HMOs, and has contracted separately with one third-party administrator to handle the business of all employers in the coalition. The administrative costs are being “unbundled” from service costs, with HMOs forced to demonstrate to employers their “value-added” compared to provider organizations.

All the restructuring that is underway, however, has thus far not altered two key characteristics of the U.S. delivery system. First, excess capacity in the hospital system remains, and is actually worsening. Occupancy rates nationally fell from 64.5 percent in 1990 to 60.3 percent in 1994 (Donham, et al. 1995). Second, the proportion of physicians who are generalists remains relatively low compared to other countries. An estimated 34 percent of U.S. physicians were generalists in 1992, similar to Germany, but much lower
than the corresponding proportions in Canada (53 percent), England (59 percent), and other industrial countries (Whitcomb 1995).

The U.S. is headed for a physician surplus. According to one estimate, a surplus of 163,000 physicians overall, or 30 percent of all patient care physicians, is forecast. Most of this surplus involves specialty care physicians; primary care physician supply and requirements are forecast to be close to equilibrium (Weiner 1994).

In summary, providers in the U.S. are experiencing relentless pressure from MCOs and employers to cut fees and reduce the use of services, interacting with excess hospital capacity and a growing surplus of specialist physicians. Physician autonomy is being battered by various practices of third-party payers that interfere with clinical decision-making. Physicians are organizing into integrated systems that hold the promise of regaining some of this autonomy. Some of the waste and inefficiency is being wrung out of the system, and some promising efforts to measure outcomes and provider performance are slowly developing. But the long-term forces driving spending — involving an aging population, new technology, behavior, and consumer wants and needs — are largely unaddressed. Access problems are worsening and we are slipping into a Darwinian world in which low-income people and those who are sick and disabled are not properly protected.
III. EXPERIENCE IN OTHER COUNTRIES

The purpose of this section is to explain the basic features of other countries' health care systems, with an emphasis on contrasting the way they approach the problems of cost, quality, and access to the U.S. strategies noted above.

There are several myths about foreign health care systems. This report will try to puncture them and present a balanced, accurate picture.

The first myth is that foreign health systems are all "socialized medicine" and are more or less similar systems run by national governments. The reality is quite different. There are three very different models of national health systems. First, there are income-tax based, government operated health care systems. Health care plans in the United Kingdom and Sweden exemplify this approach. Even in these countries, administration occurs largely at the local government level.

Second, there is a largely income-tax based national health insurance model. The government provides most of the financing but does not operate the system. This model is exemplified by the Canadian health care system. It is important to note that Canadian employers provide private supplementary insurance covering such services as dental care and prescription drugs, which are not covered for the nonelderly population under the national plan. The Canadian system is administered at the provincial level, with provinces establishing supplemental financing through payroll taxes. Provinces also negotiate fees with providers.

Third, there are payroll tax-financed health care systems with multiple, publicly-sponsored trust funds, usually called sickness funds. This model is found in Germany, France, and Japan. Employers and employees contribute through payroll taxes to sickness funds, usually related in some way to the nature of their employment. The funds, in turn, negotiate fees with associations representing physicians. In some cases, employer, employee, and public representatives sit on the boards of the sickness funds. Although payroll tax financing is the predominant mode of paying for care, general revenue financing covers special needs in the system.

Private insurance plays a role in each system. In France, private supplementary coverage is sponsored by employers and complements publicly-sponsored coverage. In Germany, about one out of ten people obtain private coverage instead of participating in sickness
funds. Once they opt out of public coverage, however, they cannot return. In Japan, employer-sponsored health insurance plans cover about five of eight people, and some of these plans are managed by private health insurance societies (Iglehart 1988a).

A number of countries with national health plans have introduced some incentive-based reforms in recent years. For example, the Netherlands has developed a plan in which premiums may differ across insurers (though each insurer must charge the same premiums to each customer). This is designed to encourage competition among insurers. To make this work, a central fund compensates insurers that enroll a large number of high-cost individuals through risk-adjusted payments tied to age and health risk (Spanjer 1992).

The payroll tax financed systems in Germany, France and Japan are closer to the U.S. system than the systems in the U.K., Canada, and Sweden, and therefore, will receive more attention in this paper. Although employers do not establish and manage company plans in Germany and France, they are the major source of financing and have a direct stake in cost control. Administration of the systems occurs largely at the local level. The notion of a federally-run system is very misleading under this model.

**A Different Approach to Access**

A fundamental difference between the U.S. health care system and the systems in France, Germany, and Japan is that coverage is nearly universal in these three countries. The only exceptions tend to be people who are homeless or for other reasons are completely outside the social system (this tends to be only 1 percent or less of the population). Health coverage is not lost when workers lose a job or change jobs. Workers may switch from one sickness fund to another, and the funds are reimbursed by government sponsored unemployment funds (or, eventually, social welfare payments) when workers become unemployed.

These systems virtually guarantee coverage to all their citizens, including the elderly, the disabled, and people with chronic health conditions or high risk factors. The type of risk selection that characterizes the U.S. system is not a major problem in these countries although Germany has experienced some problems with certain sickness funds having a disproportionate share of older workers. The universal nature of health coverage in these countries is a principal strength of their systems. It contrasts sharply with the U.S. approach.
While other industrial countries have virtually universal coverage, they typically did not achieve this in one great leap. For example, the German health care system began in 1883, and initially covered only manual workers. In 1911 the National Health Insurance Act increased the legal income limit for workers to be insured under the statutory program. By 1914, 23 percent of the population was insured. The proportion of publicly insured patients has grown steadily, and in stages since that time, to a current coverage rate of about 90 percent. Most of the remaining people (higher-income professionals) buy private coverage (Graig 1993).

Finally, we can learn some valuable lessons from other countries about long-term care. The U.S. system follows a welfare model, with virtually no help for families until they are destitute, followed by assistance tied to entering and remaining in a nursing home. While other countries face the same challenges that we do and have discovered no "magic bullet," some have found ways to help keep people at home and in the community by paying for certain social services that help keep people independent. Some countries also provide limited coverage for long-term care for all residents, not just the poor.

**Different Approaches to Cost Control**

Another important difference between the U.S. and other countries involves cost control. Under the varying models of national health systems, government establishes hospital budgets and maintains very tight control over the allocation of diagnostic equipment and other forms of physical capital.

There are two important differences between the way physicians' practices are reviewed and regulated in the U.S. and in countries with payroll tax-based systems and sickness funds. First, physicians' practices are largely monitored by other physicians abroad, with less detailed oversight by insurers, government, or managed care organizations. Second, the physician regulators generally do not exercise before-the-fact clearances of physician services. In other words, when a physician wants to order a battery of diagnostic tests or refer a patient to another physician for a consultation, typically neither the physician nor the patient has to obtain the approval of the payer. Monitoring is done ex post, and outliers are subject to financial penalties. In general, physicians are more free to practice medicine with less routine oversight in other countries than in the U.S. today.
Physician fees are negotiated between local organizations representing physicians and the sickness funds in the German, French, and Japanese systems. These negotiations result in very tight fee schedules, based on a point system related to the time, skill, and resources required to perform various medical tasks.

In Germany, physicians experienced very unpleasant regulation by sickness funds prior to the early 1930s; funds employed physicians in closed panels, dictated terms of employment, and froze out other physicians. After prolonged strikes, the physicians formed *kassenarztliche vereinigungen*, or KVs to negotiate annually with sickness funds over the total amount they will receive and to serve as fiscal intermediaries between the funds and their member physicians. The physician-controlled KVs have had utilization review programs for decades. Since there is prospective budget limiting increases in overall physician spending, and rigid fee limits, the KVs have a powerful incentive to monitor over-utilization — if they do not, the more conservative physicians are penalized for the excess utilization engendered by others. The “points” awarded to overutilizing physicians are “devalued” so that their extra volume does not earn them extra revenue (Knox 1993).

German physicians do not have the right to payment in full for all the services they bill although the sum of their bills determines payment for the KV group as a whole from the sickness funds. Individual doctors are paid through fee distribution plans developed by the KVs. The KVs employ *kassenlöwen*, or “fund lions,” who establish triggers (e.g., utilization exceeding a regional norm by more than 40 percent), and physicians who awake the “sleeping lions” can expect to get automatic reductions in reimbursement for excessive components of bills unless they can justify the excesses in terms of case mix, complexity, etc. In reality, though, only about 7 percent of physicians are called on to justify their practice patterns, and only 2 percent experience actual payment reductions (Knox 1993).

In France, medical societies and sickness funds play a similar role in monitoring practice patterns, scanning data for outliers, and bringing pressure to bear on physicians with practice patterns well above local norms to fall back into line. This process is now facilitated by the development of about 80 practice guidelines which are being used as benchmarks for assessing practice patterns. Physicians face financial penalties if they fail to conform to these medical guidelines, called *references médicales opposables*, or RMOs.
Tighter Macro-Management Abroad

There is, however, a tradeoff. While physicians are not micro-managed, they are macro-managed, and this affects their practices. First, countries with national health plans set “global budgets” limiting the growth in overall health care spending. Contrary to popular opinion, such budgets are usually not set by government fiat. Rather, in countries such as Germany, they emerge from negotiations among business, labor, other interest groups, and government. The groups are considered “social partners” in the health care system, and they have a say in determining the amount spent on health care.

Second, many countries set prospective budgets for ambulatory care that put a lid on total billing by physicians as a group. These budgets are also more likely to be set through negotiations than by government fiat.

Third, a number of countries control the supply of physicians through restrictions on medical education. Government officials in Canada, Sweden and the United Kingdom determine the number of students that can enroll in medical school (GAO 1994). The French government has placed limits on second-year enrollments in medical schools that reduced such enrollments from 8,600 places in 1971 to 3,500 in 1993 (Fielding and Lancry 1993).

The combination of low fee schedules and relatively loose, after-the-fact volume monitoring creates incentives for “over-utilization,” at least up to the budget cap. In effect, fees are regulated more tightly by the funds than volume is regulated by physicians’ organizations.

There is evidence that over-utilization occurs. In France, for example, physician visits per capita rose by 75 percent over the 1975 to 1993 period, from 3.60 annually to 6.29 (Creedes 1994). Hospital days per capita in short-stay hospitals stood at 1.4 annually in France, compared to only 0.8 in the U.S. (Rodwin and Sandier 1993). And despite the fact that unit drug prices are as much as 50 percent lower in France than in the U.S., total per capita spending on drugs was $276 in France in 1991, compared to $232 in the U.S. (OECD Health Data 1993).

A similar picture emerges in Germany where the average patient sees a physician nearly 11 times a year, twice as often as in the 5.4 physician visits of the average U.S. patient (Knox 1993). German patients spend less time in the doctor’s office, as the average visit was only
nine minutes in Germany, compared to 14 minutes in the U.S. and France (Sandier 1989).
The picture that emerges in Germany is one of patients being rushed through a quick
physician visit, returning for other visits more often than their counterparts in other
countries, and virtually never leaving without at least one prescription.

In Japan, excessively long lengths of hospital stays are well known (even when allowing
for differences in definitions related to the type of hospital). Physician visits averaged 12.8
per year, or about 2.5 times as high as in the U.S. (Sandier 1989). Physicians both
prescribe and dispense prescription drugs, which is likely to be one factor explaining the
very high proportion of overall health care spending accounted for by pharmaceuticals —
28 percent in 1987 (Iglehart 1988b). In contrast, only 7-8 percent of total spending is
accounted for by pharmaceuticals in the U.S.

How Rationing Really Works

Another myth about national health plans is that these systems have legislation that places
statutory age limits on certain types of care (kidney dialysis is the favorite example). This
claim is simply unfounded. What is true is that both global budgets and separate budgets
for hospital and ambulatory care force physicians to set priorities. As a result, there are
often gaps between virtually unlimited patient “needs” and tightly constrained resources.
This means that implicit rationing must occur in order to stay within the budget. This
rationing involves the judgments of medical professionals, often in consultation with
patients and families. But physicians abroad often find that they are short of resources, and
they may have to say no when they would like to say yes.

Thus, while physicians abroad do not have third party payers breathing down their necks,
their practice patterns are constrained by fixed budgets. In other words, their practice
patterns are not subject to point-by-point restrictions, but they cannot simply order
unlimited tests or perform heroic interventions under any circumstances. There is a
constraint, but it is a very different type of constraint. In other countries, the understanding
of the need to set priorities in order to live within a budget (as opposed to legislation) will
often lead a physician to recommend to a patient’s family that no further treatment be
given. Typically, this is worked out amicably between physician, patient, and family
(Aaron and Schwartz 1984).
Generally speaking, there is a good understanding abroad about the need to limit, through voluntary means, the provision of health care in futile situations. Furthermore, there is little threat of litigation driving the physician to provide the service, and no law requiring the physician not to provide it.

Of course, implicit rationing occurs in the U.S. as well. It unfolds when some people are priced out of using medical care, or screened out of insurance coverage because of serious risk factors such as being HIV positive. Rationing occurs more explicitly when factors such as age, family status, and prospects for recovery are taken into account in deciding who can receive various types of organ transplants. Each year, thousands of people who qualify for surgery are placed on waiting lists; many of these people die while waiting for a needed organ transplant.

In some countries, such as Canada, queues for some health services are a manifestation of tight budget constraints. It is not uncommon for patients in Canada to wait several months for certain types of surgery. Emergencies are given priority. Furthermore, Canadians are not "pouring over the border" in droves to use U.S. services, although there are isolated cases of this phenomenon. But many patients are inconvenienced, and patients who wish to be treated by their particular choice of a specialist often wait months for scheduled surgeries. Both discomfort and anxiety may be involved in waiting for services (e.g., patients with angina awaiting coronary surgery). Moreover, there are some risks in waiting for services; triage is not a perfect process.

What does not occur in other countries is the endless proliferation and duplication of plant and equipment, with attendant cost implications that we experience in the U.S. While these countries avoid the problems of excess capacity, however, they sometimes suffer from the opposite problem as fiscal constraints lead public officials to squeeze capital budgets, leading to under-care and the obsolescence of plant and equipment. This can affect the quality of care delivered.

Some countries, however, seem to find an acceptable balance. In Germany and France, for example, there is little evidence of queuing and unmet patient needs while health care spending has remained stable as a proportion of GDP (about 8-9 percent). But in other countries, such as the U.K. and Canada, the authorities appear to be under-funding health care, leading to certain sacrifices in the quality and availability of care.
Thus, while physicians are not constantly second-guessed by managed care bureaucrats, they are often forced to work with limited, and in some cases, out-of-date resources. This kind of constraint will often not show up in life expectancy statistics. The squeeze on budgets is not killing people in other countries, as witnessed by the fact that life expectancy is as long or longer in those countries as in the U.S. Quality of life, however, may suffer. A hip transplant on an 80-year-old that is delayed or not performed because it is deemed low priority in a tightly constrained budget environment may not change life expectancy, but it does change quality of life. Similarly, if a physician is forced to use outmoded diagnostic equipment, it will handicap the ability to identify certain types of medical problems. Often, these give-ups will appear marginal, from a macro viewpoint. But to the individual patient, the sacrifice will be very real.

**Administrative Costs**

Administrative costs are substantially lower under national health systems. There are two sources of savings. First, with most national health systems, there is uniformity in billing that the U.S. does not have under a multi-payer system. Second, national health systems do not rely on all the paper claims for each service that occur in the U.S. system.

There is a downside to the low administrative costs. While some of the administrative costs in the U.S. system reflect waste, a portion reflects the efforts of third party payers and self-insured employers to reduce excessive utilization, inappropriate care, and “moral hazard” — the tendency of people with insurance to spend more of the insurer’s money than they would spend if they were paying themselves. Evidence of this under-investment in techniques that uncover inappropriate and excessive care is found in the data on utilization cited earlier.

In addition, administrative costs may be under-counted in national health systems. Some of the administrative costs that are “monetized” and apparent in the U.S. system are incurred in other countries, but buried in government budgets. Such costs are concealed as staff costs associated with the government personnel at the federal and local levels who help run the system (Danzon 1993).
Medical Malpractice

An important difference between the U.S. and other countries is the litigation climate. In the U.S., a relatively small proportion of those injured or harmed by medical treatment seek legal redress. According to the Harvard Medical Practice Study, less than 2 percent of a large sample of patients injured through negligence in a hospital filed a malpractice claim (Leape, et al. 1991). Yet, in some cases, huge awards are received, including damages for pain and suffering that may far exceed the amount of money required to compensate the patient for out-of-pocket costs and forgone earnings. There is also little, if any, correlation between whether a physician is sued and whether he or she practices high quality medicine. The Harvard study showed that in many cases where a suit was brought, no physician negligence was present.

The lure of this “big hit” interacts with the way attorneys are paid for tort liability cases in the U.S. to create incentives for those plaintiffs who do come to court to seek very large awards. Under contingent fee arrangements, attorneys’ fees are directly proportional to the size of the award. This makes it possible for lower-income patients to afford legal action but creates incentives to inflate the amount of damages sought.

The fear of huge awards that can wipe out a medical practice leads U.S. physicians to load up with very costly medical malpractice insurance. The same concerns are thought by many to lead to the practice of “defensive medicine,” in which physicians order more tests and perform more procedures than they would otherwise deem prudent, in order to protect themselves in the event of future litigation.

The evidence on the extent of medical malpractice has been somewhat mixed and inconclusive. According to one study, a mid-range estimate of the cost of defensive medicine is $9.9 billion, in 1991 dollars (Rubin and Mendelson 1993). The methodology used in this study, and an earlier one by AMA researchers, has been challenged, and a 1994 study by the Office of Technology Assessment concluded that the cost of defensive medicine cannot be measured with confidence (Office of Technology Assessment 1994).

In other countries the litigation climate is quite different. Multi-million dollar awards are virtually unheard of, and attorneys are usually paid on the basis of their time instead of the size of awards. Moreover, in Canada, the losing party in litigation pays legal fees for both parties. Also, the Canadian Medical Protective Association (a physician-owned insurance program) vigorously defends those physicians that it believes have not been negligent, and
generally pays when the physician is wrong. Another important difference from U.S. practices is that malpractice cases in Canada are usually heard by judges alone, without juries.

There are several reasons for the difference. One reason is that in other industrial countries, more fully developed social insurance systems, including disability, assure that people who are harmed by medical procedures will be financially taken care of — they do not need to go to court for this reason. A second reason is that other societies tend to use regulation more than litigation to deter dangerous practices by businesses and professionals. A third reason why malpractice litigation is so heavily relied on in the U.S. is that the proportionately few physicians who have really bad records regarding malpractice are often not effectively disciplined or held accountable by state medical societies or other organizations of physicians. The role played by the KVs in Germany, for example, has no real analogue in the U.S. Lacking such an “internal” mechanism to assure accountability, U.S. physicians have become highly vulnerable to “external regulation” by both private and public payers.

The Bottom Line for Physicians

Physicians working under national health plans have more autonomy and flexibility, in general, than their counterparts in the U.S. This is ironic and surprising to many who think of physicians in other countries as either all government employees or as groaning under the yoke of intrusive government regulation. Generally speaking, U.S. physicians are subject to a greater “hassle factor” from both private managed care organizations and government payers than are their counterparts abroad.

This distinction can be recast in terms of accountability. U.S. physicians are increasingly held accountable for each medical decision by a representative working for an MCO, an employer, or government. They are also individually accountable to the legal system for their practice decisions, with huge consequences. Particularly outside of group and staff model HMOs, or newly formed Provider Sponsored Organizations (PSOs), there is little accountability to their peers.

Physicians abroad have more freedom and flexibility in their practice patterns, but are held accountable to their own professional groups in this regard. They are under continuous and strong pressure from either government or sickness funds to hold down their charges. This
is a source of considerable friction in many countries, and in a few cases, can actually lead to strikes by organized groups of doctors.

The importance of flexibility in practice patterns as an offset to tightly constrained fees can be seen in data on physicians' earnings. Many physician fees in Germany are a fraction of U.S. levels. In one study, German physicians' fees for initial exams were 20-28 percent of what Medicare pays (which is below the private U.S. market) while German fees for a follow-up exam ranged from 15-36 percent of the Medicare level (Knox 1993). Fees for diagnostic tests were more in line with U.S. levels. Yet, German physicians' earnings were measured at 4.4 times the average wage, compared to a factor of 3.9 in the U.S., reflecting the offsetting difference in volume of services. More startling is the corresponding ratio of physicians' earnings to the average workers' earnings in Japan — 7.3, or 87 percent above the U.S. ratio. That this could occur in a country such as Japan — that has one of the lowest per capita spending levels for health care of all industrial countries — reflects the fact that other countries have found ways to control health spending while still allowing physicians considerable freedom to practice and to be among the highest paid professionals in the nation. Of course, in most countries other than Japan and Germany, physicians earn less, and in some cases, substantially less than their U.S. counterparts.
IV. RECOMMENDATIONS

What can we learn from the health care systems in other countries that can help us face the challenges ahead? What modifications in our current system would be in the best interests of patients and physicians? Physicians can take the following actions to help achieve their goals:

1. Get directly involved in reducing inefficiency and improving health care quality

   - Physicians must take the lead in developing standards for physician participation in health plans and an effective self-monitoring system to substitute for micro-management by payers

The U.S. could learn from experience in other nations where effective cost control is achieved without the harassment of physicians and patients that has become a familiar part of the U.S. managed care landscape. The goals of managed care are sound, and its ability to help control costs and improve health outcomes should be tested. It would be futile to attempt to turn the clock back to a time when purchasers passively underwrote prevailing fees and practice patterns and few questions were raised about the appropriateness of health care services. There has been too much evidence of questionable and inappropriate care to simply scrap the trend toward managed care.

Nevertheless, the way we approach managed care can be altered to make it less intrusive and more respectful of the doctor-patient relationship. *The key is to rely on the very careful development of standards for accepting physicians and allied medical personnel into a network, coupled with periodic reviews of overall performance using norms established through research and the development of medical protocols.*

Physicians need to take the lead in establishing and widely disseminating information on best medical practices. This, of course, is underway, but we have a long way to go before the rank-and-file practitioner around the country has this information and is held accountable for using it in practice decisions.

The best way for physicians to get out from under the yoke of micro-regulation by both private and public payers is to help those payers develop an alternative. If physicians are perceived as fighting a rear-guard action designed to return to the days of “unmanaged”
care, they will not have credibility, and will not be taken seriously by health care purchasers.

Physicians and other providers are at a crossroads. The natural reaction by some is to want to restore the days when buyers were passive or to push for laws requiring managed care organizations to accept all physicians in their networks. But this is doomed to fail because purchasers have greater clout now and are more knowledgeable about what they are buying. A better path involves the development of a proactive agenda to control costs in a way that promotes quality and to improve access to care.

Under the strategy recommended here, physicians can take two approaches:

- Physicians can work with managed care organizations (including physician-sponsored plans) to develop clear standards for physician participation, whether under employment or contractual arrangements. Physicians’ credentials and established practice patterns would be taken into account both at the point of entry into a plan and at regular periods of “recertification.”

- Physicians can become more active in reviewing physician practice patterns, as they do in other countries.

Of course, physicians must observe federal guidelines regarding acceptable practices that do not violate anti-trust guidelines. But physicians have considerable freedom to engage in the various activities related to managed care, including sharing information about quality and utilization. Physician networks are rarely challenged on anti-trust grounds. Indeed, over the past two decades, only 11 price fixing actions have been brought against groups of physicians, and these often involved collectively negotiating fees or threatening a boycott of certain payers (Werner 1996).

The Federal Trade Commission and the U.S. Department of Justice have issued policy statements giving guidance to providers about “safety zones,” or activities that would not normally be challenged. These guidelines include activities in which physicians work with health care purchasers to improve the quality and efficiency of care. Indeed, in August, 1996 the Federal Trade Commission issued new, more flexible guidelines covering allowable practices by physician networks. Thus, while physicians need to be aware of the boundaries of acceptable practices, they have ample latitude to become more active in
reviewing the practice patterns of their colleagues and helping to establish guidelines and protocols that define best medical practices.

To say that physicians have the legal flexibility to help in policing their own ranks is not to say that the task is easy. In many areas where oversight is necessary, the mechanisms may not exist and will have to be developed. Identifying inappropriate practices and “outlier” physicians will never be a pleasant task, and imposing penalties on peers whose behavior is unacceptable will always be difficult. But the alternatives are to do nothing, which is not good for patients and unacceptable to payers, or to have detection and enforcement imposed externally by non-physicians, which is not attractive to most physicians.

The message here is that restoring physician autonomy comes at a price. That price will involve physicians being subjected to objective criteria for entry into a network, as well as the periodic review of their practice patterns. Physicians need to be the leaders in developing such entry criteria and in peer review. If physicians put their own house in order, they will be well positioned to force third parties to back off.

- Allow a market to operate

Of course, managed care organizations are frequently frustrated in their efforts to be selective in choosing physicians by anti-managed care laws. “Any willing provider” laws, for example, cut directly against the grain of the approach recommended here by blocking plans’ attempts to limit the size of their networks.

These laws raise plans’ administrative costs by forcing them to establish credentials for and monitor the practice patterns of more providers than they need. The laws limit the ability of health plans to use performance as a criterion for provider participation, as a substitute for expensive claim-by-claim monitoring. This substitution of front-end criteria related to quality and performance for micromanagement is precisely the approach called for in this report.

So-called “freedom-of-choice” laws, which force health plans to provide consumers with unrestricted choice of providers, also work against the effort to improve quality and control costs. “Fair reimbursement” laws limit differentials in payments to network and non-network providers. If purchasers are forced to treat efficient and inefficient providers identically, they lose an important tool to change provider practice patterns.
These laws, taken together, represent protectionist efforts that hamper the achievement of a more efficient health care market. Although they are enacted in the name of quality, they could dilute serious efforts to improve it.

Some physicians have been in the forefront of the effort to support these laws, which taken together, require payers to “treat all doctors alike.” But this flies in the face of how a real market works. Purchasers must have the ability to select the service providers with whom they do business. They must be able to steer patients to those providers with the best performance records. Physicians will gain credibility with buyers if they recognize that they are in a market and must have their performance assessed just as all other professionals do.

The alternative to micro-management involves untying the hands of bill payers to recognize and act on demonstrated differences in performance through being selective about which physicians can join and remain in a plan and to use differentials in reimbursement to steer patients toward the physicians with the best performance records. Performance should be measured by tracking the health outcomes of patients, while taking into account variations in the severity of illnesses. The measurement of health outcomes should be combined with information on charges so as to hold physicians accountable for both cost and quality. Physicians should insist, however, that they are involved in developing these performance measures, and not subject to arbitrary rules imposed by payers.

Perhaps the most obvious way for physicians to achieve these objective within managed care is for physicians to form their own managed care plans. Locally based physician-sponsored plans put physicians in charge and free them from having to answer to standards and rules set by some faraway central office of a large national insurer. To stay competitive, however, such plans must be efficient. So participating physicians would still be subject to monitoring and would have to be accountable for their practice behavior; they would still have to follow rules and meet standards. But they would have ultimate responsibility for shaping those rules and standards and for ensuring that they are consistent with good patient care and workable for practicing physicians.

- Work against the practices of bill payers that can jeopardize the quality of care.
Having established their credibility with payers by supporting the legitimate exercise of the rights of purchasers in the marketplace, physicians will be well placed to strike out against those practices that are inimical to patients' best interests. These include:

- "gag clauses" that block physicians from imparting information to patients on how they can obtain needed services outside of a network;

- payment practices that force providers to risk not getting paid if care is given in a situation that could be life-threatening but turns out, after-the-fact, not to have been life threatening; and

- reductions in covered services that jeopardize the health of patients.

• Cooperate with efforts to reduce administrative costs.

The U.S. should accelerate efforts underway to reduce administrative costs. Such costs will inevitably be higher under our multi-payer system than under the national health plans used in many other countries. But we can take steps to reduce the additional costs resulting from a lack of uniformity in claims forms across multiple payers and the continued reliance on paper claims instead of electronic transfer.

• Payers and providers need to work together within communities to streamline payment procedures; a good start is the acceptance throughout a community of uniform claims forms.

• Communities can start by getting all providers and payers "on line" to share information on claims reimbursement electronically.

• Physicians should learn to contract directly with employers, as is now beginning to occur in Des Moines and Minneapolis/St. Paul. If physicians believe that the rules and regulations of "middlemen" are becoming too burdensome and expensive, they can circumvent them. Many physicians are involved in physician-hospital organizations and other vertically integrated systems. Such organizations can develop direct contractual relationships with employers — public and private.

• Work with payers to reduce unnecessary and inappropriate medical care
If physicians wish to regain some of their autonomy and preserve their independence, they must work together and with payers to identify and reduce unnecessary and inappropriate medical care. This is not an easy task.

- Efforts are now underway to measure quality of care and health outcomes, but they are inadequate and under-funded. At the federal level, Congress has cut the budget of the Agency for Health Care Policy Research, an organization dedicated to measuring quality and developing medical protocols, and may do so again. Physicians should support an adequately funded AHCPR to assure that it can uncover and disseminate information about best medical practices.

- There are some exciting efforts to identify and reduce inappropriate care underway in the private sector (e.g., the ICSI in Minneapolis/St. Paul noted earlier). But for many payers, particularly small and medium-sized firms, purchasing decisions are made mainly on the basis of lowest cost.

Payers and providers share the responsibility for changing this situation and moving health care quality to the front burner of health policy. Of course, the search for quality will not always lower costs — there is “under-care” as well as “over-care.” But, on balance, there are likely to be net savings.

Physicians and hospitals should help guide the drive by purchasers for savings and insist that quality be built into it. If they do not, they will be subject to “death by a thousand cuts” as purchasers make continued thrusts to cut costs. The message to physicians is to take control of their own destiny. To complain about insurers and MCOs will yield few results.

- Help make information available on provider performance

To develop an alternative to third-party harassment based on the less-is-beautiful model of cost control, physicians and hospitals must support and be directly involved in the effort to collect, organize, and publicly disseminate information on provider performance.

Physicians can also support state data commissions. In the absence of such support, these commissions can be vulnerable to interest group opposition. In Colorado, for example, a state data commission was terminated in 1995 despite its record of accomplishment in
developing useful reports on provider performance. Similar developments have occurred in other states. These events are a setback to cost control strategies based on comparative information about cost and outcomes. If strategies based on identifying best practices and channeling patients to providers who use them are stymied through efforts to block the distribution of sound data, payers will resort to “buying cheap” and simply driving down utilization across the board.

- To facilitate comparisons of provider performance, local data repositories can be established. Information on provider costs and outcomes, adjusted carefully for case mix and severity of illness, can be objectively analyzed by researchers and made publicly available. (It would be a mistake, of course, to underplay the technical and methodological challenges involved in developing such provider profiles.) It is important that physicians play a lead role in developing the information used to assess their performance.

2. Support the use of capitation as a microcosm of a global budget.

The formula that seems to be holding down spending in other countries is a combination of 1) a global budget, with separate “sub-budgets” for hospital and ambulatory care; 2) physician fee schedules; and 3) monitoring of volume levels by physician-run organizations.

The U.S. is unlikely to adopt the type of budget used in most other industrial countries on a formal, nationwide basis. Yet, Medicare has already moved in the direction of a fixed budget for ambulatory care under Part B of the program, and both Medicare and Medicaid could be subject to some form of a “global budget” under pending legislation.

Both private and public employers, along with Medicaid, can make greater use of capitation payment arrangements in which health plans are paid a fixed amount per enrollee for care. Plans, in turn, may shift some of the risk they incur to providers by negotiating capitation arrangements with them.

The advantage of this approach is that capitation arrangements are like “mini-global budgets.” Thus, their widespread use at least has a chance of addressing the powerful forces driving up health care spending noted earlier—technology development in particular. Per capita payments will force providers to set priorities among competing health care needs in much the same way as global budgets.
Capitation payments incorporate incentives to conserve resources that are similar to those built into global budgets, while allowing flexibility in the way risks are shared. In some cases, health plans may be capitated by employers but pay providers on a fee-for-service basis. In other cases, the plans may partially capitate primary care physicians (e.g., for primary care only), while in other cases, the "sub-capitation" covers referrals to specialists. Plans differ with regard to whether physicians are held accountable for the cost of inpatient hospital care.

A key difference between a strategy based on global budgets and one based on capitation is that there is no externally imposed ceiling on capitation rates — they are worked out through “internal” negotiations between payers and providers. As a result, capitation is less certain to control the overall rate of growth in costs. But capitation does create incentives to economize on the use of services. If the proper safeguards are installed to deter under-care, capitation can reduce costs without jeopardizing quality. Safeguards could include flexibility in the choice of a primary care physician for people with specialized or chronic needs (e.g., a rheumatologist serving as the primary care physician for someone with severe arthritis); initial comprehensive “intake assessments” and development of care plans including primary, specialty, and non-physician care; and periodic consumer satisfaction surveys.

It is essential to ensure that capitation rates are reasonable and actuarially sound. Unless the capitation payment system is designed and employed with sufficient sophistication, physicians will have incentives to enroll only healthy patients and avoid patients with complicated illnesses. In particular, the rates must be applied to a sufficiently large base of patients to ensure that the patients enrolled with a provider or provider group are representative of the group that formed the base for the capitation calculation. Even then, some method for accounting for an unusually unhealthy case mix may be necessary. This approach to determining capitation rates will help avert under-care and give the capitation strategy a fair test.

Through the more widespread use of capitation, the U.S. could try to incorporate the power of “caps” from abroad without going all the way to global budgets. At some point in the future, however, we may find that nothing short of global budgets will work. At such a point, our desire to control costs will conflict with our desire to let payers and providers negotiate spending levels, whatever they turn out to be. Tradeoffs between cost control and freedom to set prices and establish practice patterns are inevitable. At issue is whether we
can find a combination of cost control and flexibility that lies in between where we are today and the approaches used in other countries.

3. Work for the enactment of meaningful malpractice reform.

A number of states have enacted limited forms of malpractice reform. These efforts consist mainly of placing caps on awards, which try to put a lid on the problem without addressing the underlying causes.

Malpractice reform must balance the need to protect patients and deter malpractice, on one hand, with the need to protect physicians and other health care providers from unjustifiable claims and unwarranted financial catastrophe. Reform should reflect the confluence of two trends noted earlier — many patients who are injured are never helped, while some patients are over-compensated relative to any sensible standard of need. Reforms should also be consistent with trends in health care delivery.

Malpractice reform could involve:

- traditional reforms including caps on non-economic damages to stabilize a system that is out of control
- experiments involving a schedule of awards that guide jury decisions related to the actual financial needs of patients and their families with perhaps some reasonable amounts for pain and suffering and punitive damages;
- reforms in attorneys' compensation that reduce the incentive to “shoot for the moon;” this might include an end to contingent fee arrangements yielding lawyers a percentage of the award, and a provision requiring the losing party in litigation to shoulder a significant portion of court costs (as in the British legal system); and
- pilot projects to study health plan liability for participating physicians; this is related to the previous recommendation regarding careful selection criteria used by plans for physician participation — in return for agreeing to this front-end screening, physicians would receive greater protection. If an adverse event occurs, the plan would assume liability. This reform
4. Help bring physician supply into balance with patient needs.

As noted earlier, the U.S. is headed toward a surplus of specialist physicians. At the same time, good managed care requires an adequate supply of appropriately trained generalist physicians.

The U.S. is not likely to adopt the types of government controls on medical school enrollment used abroad. To avoid the need for such controls, physicians should take the lead in devising their own strategies for channeling medical students, interns, and residents into training that meets the changing needs of the U.S. population, and responds to the demands of bill payers. Without adopting government mandates, the U.S., with advice from physicians about the changing requirements of our delivery system, can follow the lead of countries such as France that put certain restrictions on the number of internship and residency slots by specialty.

5. Address the major cost drivers in the health care system.

To address the major cost drivers in the system, physicians should:

- Ensure the appropriate use of medical technology

A basic thrust of this paper is that managed care can only be one of several strategies we must follow if we are to control health care spending increases. The paramount importance of new technology in driving up health spending has been noted.

Other countries have addressed this problem by placing strict limits on the growth in spending, which essentially forces certain limits on technology. The U.S. does not seem ready or willing to impose such limits. Yet, we do not have to choose between global budgets and the open-ended use of new technology, with little regard to its cost-effectiveness.

Physicians must take the lead in ensuring the appropriate use of medical technology. They should not leave the task of determining the appropriate applications of a new technology to bill payers. Physicians are better placed to determine the conditions under which new tests, procedures, and medications are properly indicated.
Physicians should play an important role in developing criteria for determining where to spend scarce resources and where not to spend such resources. For example, physicians can stress the importance of preventive care measures that have been shown to be cost-effective. They can also help identify inappropriate applications of advanced medical technology that drive up costs without measurably improving patients’ health.

This approach will not produce an overnight success in reducing the growth in health care spending. It will not provide instant gratification for payers. But these should not be our goals. A better goal — and one consistent with the criteria for a health system presented at the outset of this paper — is to achieve clinical excellence without wasting resources and to make the system cost-effective. This goal can be fostered by the case-by-case assessment of new technology and its appropriate applications.

- Educate themselves and patients about having realistic expectations

The analysis of cost drivers in this paper indicated that patient expectations interact with technology and other factors in pushing up health care spending. Physicians should take the lead in educating themselves and their patients about the limits of medical technology and the likelihood of survival in end-of-life situations. Clearly, this is a controversial area, and physicians are bound by both legal and ethical considerations. Nevertheless, U.S. physicians, like their counterparts in other countries, can routinely counsel families about the prospects for recovery and the advisability of continuing heroic interventions and treatments that are not only costly, but also may prolong pain and suffering. While there are no easy answers to the question of how much health care is enough, it is important for physicians to tackle this question. Physicians can help find a middle course between dodging the issue and simply turning it over to government or private third party payers.

- Encourage healthy behavior and lifestyles

Physicians are well placed to help patients recognize the critically important relationship between their own behavior and lifestyle and their health status. To address this cost driver, physicians must take an active and visible stance that both promotes healthy behavior and deters unhealthy patient practices. Clearly, physicians have worked hard in this area.
It is time now to become active advocates in such matters as ending smoking advertising campaigns aimed at youth, taking steps to avoid sexually transmitted diseases, reducing violence, promoting safe driving, and using good sense on diet and exercise.

Physicians should also strive to include information about the lifestyle factors that drive health spending in medical education and training. Physicians need to be trained to identify the warning signals of alcohol and drug abuse, spousal and child abuse, and other behaviors that endanger health, and to make the appropriate referrals. Many of the medical indications that physicians see today are the symptoms of underlying behavior patterns that are dangerous to health.

Physicians can also help by working to assure that people actually receive preventive care services that have been shown to be cost-effective. This includes immunizations, pre-natal care, screening for cardiovascular disease, and PAP smears.

- Help plan for and adapt to projected increases in the number of elderly people

Another force that is likely to be driving up health care spending in the future is the aging of our population. Physicians can help pave the way for this change by assuring that our health care delivery system adapts to the changing needs of an aging population.

A good example involves the need to attend more to chronic illness and disability. Physicians have, quite understandably, focused on curing disease and treating illness. But as our population ages, there will be a need for a greater emphasis on helping patients cope with conditions that have no cure, but can often be managed to alleviate suffering.

Medical education and post-graduate training should emphasize these changing needs and help prepare physicians for the patient population they will face in the future.

6. Find ways to increase health coverage and improve access to care.

One lesson that we can surely draw from other countries is the desirability of moving to universal health coverage. The current system is unacceptable, and getting worse. A full treatment of this subject is beyond the scope of this report, and is addressed in a separate policy paper of the American College of Physicians. A new approach that recognizes both fiscal and political constraints might consist of:
- a plan for covering all poor and near-poor children unrelated to the cash welfare system;

- a major effort to build up the public health infrastructure through more support for community and migrant health centers, the Neighborhood Health Service Corps, and other programs; physicians can also play an important role in developing direct outreach to vulnerable populations; and

- programs to coordinate health and social services to provide coordinated care to lower-income populations, as now being pilot-tested in Hillsborough County, Florida and the state of Maryland.

7. Reform the financing of health care insurance.

The changes in the role of physicians outlined in this report do not require a major change in the way health care is financed in the U.S. We do not, for example, have to convert to a single-payer financing system in order to redirect managed care in the ways suggested here.

Nevertheless, some basic system-wide financing reforms would facilitate the kinds of changes called for in this report. First, a cap on the open-ended tax subsidies related to employer-sponsored health coverage would provide incentives for both workers and employers to be cost conscious in selecting health plans. If firms and workers faced tax consequences for selecting higher-cost plans, they would be less likely to do so, and this would put downward pressure on premiums associated with those plans.

Second, reform of the rules governing the sale of health insurance, particularly for small businesses and individuals, could help to improve access and equity. The Kassebaum-Kennedy insurance reform legislation, making coverage portable and limiting the use of pre-existing condition exclusions, should ensure that less healthy people are not denied coverage. Modified community rating, already adopted in some states, could help to spread risks more broadly among the healthy and less healthy portions of the population. There is increased interest in joint purchasing and risk-pooling activities like those underway in California, Kentucky, and Colorado.
These reforms will not solve all the problems in our health care system. But they would help assure that competition among providers and health plans is played out in terms of comparative efficiency instead of through a process of "cream-skimming" that holds down costs for one group at the expense of another.

V. CONCLUSION

Physicians must take the lead in bringing about reforms in the U.S. health care system that benefit patients. These reforms should help achieve universal access, cost-effectiveness, and clinical excellence.

The managed care movement has much to contribute to the achievement of goals related to cost, quality, and access. Yet, as currently practiced, managed care sometimes stresses cost minimization instead of cost-effectiveness, and can jeopardize health care access and quality.

The challenge for physicians is to help capture the benefits of managed care for patients while averting its pitfalls. Many physicians understandably object to the interference in clinical decision-making that can accompany efforts by third-party payers to cut costs. These physicians should work with payers to devise constructive alternatives to such practices. By playing an active role in developing standards for appropriate practice, physicians can gain credibility with those who are paying their bills, and help our health care system achieve its basic goals.
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