SECOND OPINION: EMPLOYERS CAN MAKE MANAGED CARE WORK

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FOREWORD

The Association of Private Pension & Welfare Plans (APPWP) has heard the cry that managed care is just another claimed panacea for our health care crisis that will ultimately prove unsuccessful. The APPWP has a different opinion: we believe managed care can work. Employers who have deployed managed care in their company health plans are finding soaring costs can be contained, with quality of care undiminished, if not enhanced.

APPWP members are not naive, however; they recognize that no "solution" or reform can alter an entire system quickly, especially if practiced by only one player. While employers are trying managed care to contain their costs, the federal government -- by far the largest player in the health care system -- contains its costs by shifting them to private payors. This cannot continue.

We present this discussion of managed care to answer those who want to resist it or oppose it -- and all other incremental changes to our system. Employers are anxious to see costs contained systemwide in private and public plans alike, because the debate on America’s health care system must begin with its costs.

While there are many reforms needed to the health care system, APPWP members feel that a critical element of reform necessary to contain costs and improve quality is managed care.

Managed health care programs are in their infancy, and with freedom from artificial and inappropriate constraints, they are likely to produce solutions to health care problems unique to America.

We hope that this document can contribute to the Nation's debate on health care.

Howard C. Weizmann
Executive Director

Ellen L. Goldstein
Director of Health Policy
EXECUTIVE SUMMARY

The high cost of health care has concerned government and corporate leaders for decades, but the rapid escalation of health care costs in the 1980s drove employers to seek more aggressive methods to contain costs. With managed care, employers believe that not only can costs be contained, but the quality of health care delivered can be improved by eliminating unnecessary and wasteful treatment and care.

Private employers -- who pay about one-quarter of the Nation's health care bill -- can do much to reduce these costs; managed care is one of their strongest tools. But the private sector cannot do it alone. The federal and state governments must not work at odds with the private sector -- by continuing to shift costs to private payors, ordering onerous mandates, and placing constraints on managed care. Rather, all payors must work as partners to wring out waste systemwide.

Health care costs have risen roughly twice as fast as other costs in recent years, due to the combined effects of supply and demand factors, medical care price inflation, and population growth. Today, Americans not only obtain more services, often using costly medical technology, but often those services are used more intensively than ever. Unnecessary, wasteful care results from the failure to matching medical resources to real need, and from the use of defensive medicine due to fear of medical malpractice litigation. Without managed care, consumers have few incentives to limit their use of services, and providers have no incentives to effect more efficient care.

Managed care is revolutionizing the way health care is provided in America. Employers are finding that health care costs can be lowered by reducing over-utilization, controlling prices, changing incentives and behavior that affect both price and volume, and at the same time that cost effective, higher quality care can be encouraged. Utilization review, cost-sharing, and the development of alternative delivery systems are helping to reduce health care expenditures.

America needs a sustained strategy systemwide to contain costs. Our government has a unique role as a major payor and policymaker to act as a catalyst, a facilitator, and a team player. Ending or curtailing defensive medicine, expanding preventive care and wellness programs, and expanding the provider’s knowledge -- and the consumer’s understanding -- of the effectiveness and appropriateness of a wide range of medical procedures will help reduce these wasted resources.

While we can learn much about how other nations deliver universal health care for less, most countries can learn much more from us about medical research and technological advancements. As a result others are beginning to study our experiments and innovations in cost-effective delivery of medicine. If permitted to grow and evolve, managed care programs are likely to produce unique solutions to America’s health care dilemma. For if we are to expand coverage, as we must, health care costs must be brought under control. Managed care can help America contain costs, and help improve quality of care.

There are real threats to the future of managed care; short-sighted and inappropriate constraints at the state or federal level can unduly hamstring its. The APPWP encourages policy makers at the federal and state levels to nurture and protect managed care strategies, and utilize them in their own programs.
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INTRODUCTION

Managed health care programs are improving the quality of health care delivered in the U.S. today; they may also be our last hope to rein in soaring costs. America’s employers, who provide and pay for a major portion of private health care, are coming to believe that managed health care programs will work, but success cannot happen in a vacuum; effectively containing costs requires a partnership among all players in the health care system. Without such a partnership, managed care may not fully succeed, and the chorus crying for a nationalized one-payor system will grow. That "solution" is unlikely to be better for America since it would likely jeopardize the high standards of medical care that Americans have grown to expect. Further, as health care expenditures take a greater share of corporate profits, federal spending and GNP, payors and policy makers are asking whether more health care is really better health care. Done right, managed care can deliver more appropriate, quality care more cost effectively and to more Americans than ever before.

Recent years have produced a flurry of experimentation in an attempt to find cost effective methods of providing health care to all Americans without diminishing the quality and accessibility to care which Americans have come to expect. Still, as a nation, we have not yet achieved long term control over the rate of increase in health care costs. Ideas have been tried ranging from Diagnosis Related Groups (DRGs) introduced under Medicare to mandatory "second opinions," that have produced mixed results. Other ideas for managing costs such as utilization reviews, HMOs, PPOs, and more recently, "triple option plans," are evolving into more refined forms and offer some real long term potential.

The United States is not alone in its struggle against health costs that rise much more rapidly than inflation. Countries that have universal systems and socialized medicine are encountering similar inexorable cost increases that accompany aging populations and rising expectations. In many of these countries, budget constraints seriously limit the availability of non-urgent services. The United Kingdom, for example, is now trying to inject a "free market philosophy" into its system of socialized medicine. Some U.S. policy makers have become enamored of the Canadian system at the very time more Canadian providers and patients are expressing dissatisfaction because of further constraints on providers and services, and the growing cost of the system to the government and individuals. The availability of health services to every individual, however, produces general support for these systems even when they are seen to provide inadequate services.
In the United States, private sector innovations and experimentation are beginning to produce a new consensus on health care issues including access, personal responsibility, tort reform and practice standards. A distinctively American partnership of the private sector, the federal and state governments, and health care providers committed to a sustained effort is our best hope to produce a quality, cost effective system.

The purpose of this compendium is to highlight the recent history of health care costs and health care cost management in the United States. We also examine briefly how other countries who are major trading partners deal with health care, and identify current developments that show promise in containing rising costs.

There is much to be learned from the plans of other countries, but as we will see from the section on innovative plans of U.S. employers, our system is producing uniquely American solutions that, when left unfettered by undue regulation, address the problem without compromising the systems and level of services Americans have come to expect.

Carson Beadle
APPWP Health Issues Committee Chairman
CHAPTER ONE
WHY HAVE COSTS SOARED?

Health care cost inflation has been a problem in the U.S. for decades, and different solutions to contain costs have been tried with mixed results. But it was the soaring inflation in health care expenditures of the early 1980s that led government and employers to seek and implement even more aggressive measures to control costs. To understand how today's managed health care programs can work, however, it's important first to understand why health care costs have climbed so high.

What is the Cost?

Health care expenditures consume an increasing share of the nation's resources. In 1989, the United States spent $604.1 billion -- $2,400 for every man, woman and child in the country and over 11 percent more than in 1988 -- on health care. This amount represented 11.6 percent of the gross national product (GNP), up from 9.1 percent in 1980, and more than twice the share it occupied in 1960. If current trends persist, national health expenditures may reach $1.5 trillion by the year 2000, or between 13 and 15 percent of GNP.¹¹

Health care costs are a function of numerous interrelated components that are often difficult to quantify. As the chart indicates, general inflation in the economy is only one of these factors, albeit an important one. Health care costs have risen roughly twice as fast as other costs in recent years, due to the combined effects of supply and demand factors, medical care price inflation, and population growth. The chart also illustrates the relative importance of each factor in the rate of increase in health care costs between 1966 and 1986.

Supply and Demand Issues

The use of medical services has increased steadily during the past several decades. People not only obtain more services, but many of those services are used more intensively than in previous years.

Government, private health insurance, employers and philanthropic sources pay approximately three-quarters of health expenditures in the United States. As the number of insured and the breadth of coverage grew, health care spending soared. Providers of care greatly influence the demand for services as well. Because so often third parties pay the largest share of the bill on
Factors affecting change in personal health care expenditures of billions of dollars:
Calendar years 1966-86

Source: Health Care Financing Administration, Office of the Actuary. Data from the Division of National Cost Estimates.
IMPACT OF RISING HEALTH CARE COSTS

Business Spending for Health Services...

as a % of Corporate Profits

5.3% 7.4% 9.1% 12.0% 15.0%

as a % of GNP

Source: Jacques Sokolov, M.D., Southern California Edison

[Dollar amounts in billions]

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Note: Totals may not add due to rounding.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.
behalf of health care consumers, consumers have had few incentives to limit their use of medical services. Analyses of public opinion research find that few individuals feel a personal responsibility for health care costs. Overall, the availability, delivery and use of health care defies conventional, competitive market principles.

Wide regional disparities in treatment also represent much costly and unnecessary service. A study in Maine showed that the rate of hysterectomies in different areas of the state varied from 60 to 160 percent of the state average; great variations in the performance of hemorrhoid surgery and tonsillectomies also were found. A 1984 Massachusetts study showed even greater variations. Residents of Hingham were four times as likely to have their gall bladders removed than residents of Holyoke with the same symptoms. Boston residents were twice as likely to receive a certain stroke-prevention procedure than residents of New Haven, Connecticut. Studies in Iowa, Vermont and Rhode Island show similar disturbing results. No sound medical reason explains these differences. However, the "medical uncertainty principle," of policy scholar Aaron Wildovsky, the former dean of the School of Public Policy, University of California, at Berkeley, may: to resolve uncertainty, doctors and patients "seek care up to the level of insurance." Uncertainty is therefore costly, but could be lessened with the development of protocols of medical standards.

Unnecessary services also add to the Nation's health care bill. For example, the fear of litigation may lead medical providers to perform tests and procedures that are not medically necessary. RAND Corporation and other studies estimate that from 20 to 30 percent of all medical care provided in the U.S. is unnecessary care. Further, a small portion of providers "game the system" and devise billing practices that have defrauded third party payors to the tune of billions of dollars.

Third party payment also can affect the service and pricing decisions of health care providers because there are no incentives to the provider to effect more efficient care, rather than just more care. Hospitals, physicians and others reimbursed by third parties frequently provide more services and charge more for them than an individual patient could afford using only his or her own resources. Some analysts would argue that the "market" price for most medical services is not even known, since so few consumers actually pay for the care they obtain.

Medical Care Inflation

The Nation's health care bill reflects increases in the volume of services provided as well as the cost for each unit of service. When the costs of medical services rise faster than costs for other goods and services, when more costly procedures supplant less costly procedures, and when the
number of procedures performed per diagnoses increases, medical care price inflation will rise faster than general inflation.

Most research indicates that technology and the intensity of its use contribute significantly to medical care price inflation, although its impact is difficult to quantify. Half the increase in real hospital costs between 1977 and 1983 came from the development and application of diagnostic and therapeutic measures.\textsuperscript{12} In many cases, the new technology itself costs significantly more than that which it replaced, and is used more frequently. For example, research supported by the National Center for Health Services Research and Health Care Technology Assessment revealed that new technologies for diagnosing and treating acute myocardial infarction (MI) sharply increased the number and types of in-hospital services used and the costs of physical care for this condition. Between 1972 and 1982, the number of physician services used in caring for MI patients more than doubled and resulting physician costs nearly tripled.

The limited control exerted over technological diffusion often results in an abundance of costly new procedures and devices. Between June and December 1986 alone, the number of mobile magnetic resonance imaging units (MRI) in operation at hospitals increased 519 percent, from 31 units to 192. A similar trend is evinced by lithotripters. Between March 1986 and May 1987, the number of lithotripters increased 121 percent from 58 to 128.\textsuperscript{3} While new technologies may prove more cost-effective than their predecessors on a unit basis, excessive or inadequate use serves to increase costs.

A result peculiar to medicine is that improved technology often leads to costlier care, whereas elsewhere it leads to savings, more cheaply-produced goods, and other economic benefits.

Population Change

Current and future changes in the population have had some impact on the health care system. As the population grows older, it requires more health care services. This will become more critical because the fastest growing demographic segment in the United States population is the "very old," i.e. those over age 85. As recently as 1960, only nine percent of the population was aged 65 or over. But as a result of increasing life spans and the decline in the number of births that followed the post-war baby boom, more than 12 percent of Americans are aged 65 and over today, and this share is expected to increase.

Health care spending is higher for the elderly than for any other population group. People aged 65 and over account for one-third of national health care expenditures, and per capita spending
for people between ages 65-69 reached $5,360 and up to $8,178 for those over age 85 in 1987, compared to $1,287 per capita for those under age 65. Given this rate of spending, and the aging baby boom generation, two-thirds of health care dollars will go to those over 65 by the year 2030. Ethical questions involving quality of life vs. longevity may grow more intense.

The Future of Health Care Costs

Health care expenditures continue to rise despite the expansion during the 1980s of health maintenance organizations, the introduction of preferred provider organizations, more accurate computer claims technology, numerous cost containment initiatives, and other developments. Higher health care costs also lead to cost-shifting among payors, (see charts on page 10). Costs due to increases in the number of uninsured and their uncompensated care, have also shifted to private payors.

Certain targeted strategies have in fact curbed cost increases, but expenditures continue to rise elsewhere in the health care economy. Since the introduction of Medicare's prospective payment system, (See Appendix One, Part One) for example, Medicare hospital expenditures have risen far more slowly than physician payments, which remained under a charge-based system. Medicare "savings" and cutbacks in the level of Medicaid payments are actually shifted to private payors, especially employer-sponsored plans, adding significantly to the costs of private plans, (see charts that follow).

The future course of health care costs depends on many factors, but the most important one will be how well government and the private sector work together to support managing health care costs systemwide. Private employers can do much to reduce the nation's health bill and more importantly, decrease unnecessary and often unhealthy care. But the private sector cannot do it alone. The federal and state governments must not work at odds with the private sector – by cost shifting, mandates, and constraints on managed care. Rather, government must become a committed and cooperative partner with employers to manage aggressively the health care cost explosion together.
COST-SHIFTING IN HOSPITAL SPENDING
MEDICARE AND NON-MEDICARE SPENDING
1975-1988

Hospital Spending ($ Billions)

COST-SHIFTING IN PHYSICIAN SPENDING
MEDICARE AND NON-MEDICARE SPENDING
1975-1988

Physician Spending ($ Billions)

*All data from HCFA; APPWP calculations
(Notes for Charts on Cost-Shifting)

The increase in non-Medicare hospital spending for years 1985 - 1988 was over three times that for Medicare, (32.37% vs. 10.34%), probably due to cost-shifting resulting from Medicare hospital reimbursement reforms and reductions. Increases in physician spending were similarly large for Medicare (40.69%) and non-Medicare (42.435%) physician spending. A similar disparity in physician spending growth, i.e. a distinct shift from public to private payors, may become evident later in this decade as a Medicare physician reimbursement reforms take hold.

(Non-Medicare Spending was determined by subtracting Medicare Part A and Medicare Part B, physician services from total health care spending in these areas. There may be some discrepancies between what is included under Medicare calculations, and those for national spending calculations, however certain cost-shifting trends from public to private payors are apparent.)
COST OF DEFENSIVE MEDICINE (1987)

- $121 Billion (24.2%) Defensive Medicine
- 4 Billion (0.8%) Medical Malpractice
- $375 Billion (75%) Necessary Care

(Source: Joseph Catalano)
CHAPTER TWO
EMPLOYERS BATTLE HEALTH CARE COSTS

Because employers provide health care coverage to over 90 percent of their full-time employees and pay around 25 percent of the Nation’s health care bill,\textsuperscript{5} ever-rising health care costs have driven them to deploy more effective weapons. Health care costs have soared as a percentage of corporate profits since 1960 when they represented 7 percent of profits, to 38.1 percent in 1980, and 48.3 percent in 1990. The increase in the share of costs paid by private health insurance outstripped the overall increase in health expenditures in the 1980s. If current trends continue, health care costs may represent 60 percent of corporate profits by the year 2000.\textsuperscript{6}

Managed care is revolutionizing the way health care is provided in America. Employers are finding that health care costs can be lowered by reducing utilization, controlling prices, changing incentives and behavior that affect both price and volume, and at the same time cost-effective, higher quality care can be encouraged. Today managed health care and other cost containment features are growing and evolving rapidly, and shaping the majority of health care delivered in the United States.\textsuperscript{7}

Overall, managed care strategies can reduce society’s total level of health care expenditures.

Employers’ battle to control costs has been waged on four fronts: First, employers tried to increase the internal efficiency of their benefit programs by improving plan administration, enforcing coordination of benefits, verifying eligibility more carefully, fine-tuning the criteria for reasonable and customary reimbursement, and/or self-funding part or all company medical costs.

Second, employers initiated cost-sharing with employees through such means as comprehensive benefit plans, replacing first dollar plans with plans that require higher deductibles and employee contributions, and limiting benefits provided. A third element was utilization management which includes pre-certification of hospital admissions, reviewing length of hospital stays for patients, reviewing providers retroactively to identify excessive treatment, patient discharge planning, seeking more economical post-hospital care facilities, and active management of major cases.

A fourth phase to control costs saw employers turning to alternative delivery systems such as HMOs and PPOs (and their derivative versions), to multiple option plans designed to encourage employees to use a provider network where costs are better managed. There are even company-sponsored medical clinics popping up in different areas of the country.
As a result of these varied responses, the private sector has developed a more sophisticated understanding of health care costs which it is using as a basis for developing more refined programs. The current tools of cost management are described below.

**Utilization Review (UR)**

Under UR, individual patient care decisions by physicians and other providers are reviewed by third-party payors. UR is aimed at attacking unnecessary and inefficient health care services, and modifying physician behavior through peer review and feedback. UR programs identify appropriate care and criteria, and review requests for treatment either prospectively, concurrently or retroactively. UR can also operate as a patient advocate program, appropriately guiding the patient through a health care system that is becoming more and more complex and confusing.

Around 80 percent of health care dollars today are subject to some form of UR. The surge in UR can be tied to Medicare requirements for UR which now utilize professional review organizations (PROs), described Appendix I, Part One. UR is also a standard feature of HMOs and PPOs. UR has been shown to have a positive effect on holding down costs, and it has great potential for improving the quality of care as well. However, it is but one of several devices that hold down long-term rates of increase and even then, requires constant monitoring.

**Cost-Sharing**

Cost-sharing makes beneficiaries more sensitive to the price of health care services. The total volume of services can be reduced while preserving the protection afforded by insurance. Cost-sharing techniques include beneficiary deductibles, coinsurance, and copayments. Increased premium sharing provides incentives for employees to choose less costly and more efficient plans when given a choice. Studies have demonstrated that cost-sharing can reduce utilization and cost dramatically compared to first dollar coverage, and generally without negative effects on patient health.

**Alternate Delivery Systems**

Traditional fee-for-service payment systems have built-in disincentives for cost-effective health insurance utilization because third party payors merely paid the medical bills according to pre-determined rates and proportions with little questioning of volume and appropriateness of services and treatments. Alternative delivery systems such as HMOs, PPOs, and their derivative forms -- including fee-for-service plans -- have been deployed in recent years to alter this situation.
HMOs: Health-maintenance organizations have grown significantly in the 1980s, although prepaid group practices date back to the 1930s. Various governmental statutes and regulations have led to significant growth of HMOs since the 1970s. Generally, HMOs are paid a fixed fee for patients, provide all or most needed care, and usually bear the financial risk of meeting those requirements. Doctors' compensation is linked to how well and how efficiently care is provided; however, the linkage varies under the different HMO models.

Staff model HMOs employ physicians, generally salaried, who practice in one or more centralized ambulatory care facilities. A group model HMO contracts for services with physicians who are employed by a multi-specialty practice. Depending on their arrangement, physicians in these HMOs can sometimes see non-HMO patients, they may own the HMO, and they are compensated either on a capitation or cost per treatment basis. More recently, IPA model HMOs (independent practice association) have grown the most. IPAs contract with independent physicians, whereas network model HMOs contract with both independent physicians and medical groups.

Historically, HMOs have been shown to save from 10 to 40 percent over fee-for-service medicine, largely as a result of lower hospitalization costs.\(^{11}\) However, health care analysts have questioned whether these numbers represent a one-time savings and/or whether they resulted from covering younger, healthier beneficiaries. During the double-digit increases in health insurance premiums in 1983 and 1987-88, HMOs did experience rate increases substantially below fee-for-service plans. However, there is an abiding concern that first dollar care will encourage subscribers to make more routine use of the services and drive up costs. In 1987, fourteen percent of all Americans -- or one in seven -- were enrolled in an HMO.\(^{12}\)

PPOs: The concept behind preferred provider organizations (PPOs) is to negotiate contracts with a selected group of cost-effective providers and channel patients to them through benefit incentives at point of service. The assumption is that the combination of reduced provider prices and efficient providers (reinforced by rigorous UR) will keep costs down. The 1980s saw a dramatic growth for PPOs; the term had not yet been coined in 1980 but by 1984, approximately one million Americans had been enrolled in PPOs. By 1990, around 24 percent of Americans covered by employer-sponsored insurance were eligible for PPOs.\(^{13}\) As they evolved late in the decade, PPOs began to establish more rigorous standards for screening and monitoring providers. Reimbursement arrangements became more sophisticated, with payment based on specified fee schedules. PPO flexibility allows participants the option of going outside the provider panel, but at higher out-of-pocket costs, thereby retaining direct user involvement in the cost of care.
Insurance companies or self-insured employer plans generally bear the financial risk for care, but some PPOs have assumed some of this risk. They have incorporated many of the utilization management features that had proven so successful in HMOs, particularly the "gate keeper" physician who, in some of these programs, is responsible for evaluating patients' symptoms and referring them for appropriate treatment.

Different types of PPOs have emerged, such as hospital PPOs which do bear some of the financial risks for excessive care.

The pressure to remain competitive means that as they mature and evolve, PPOs will develop more economic and efficient health care delivery, while maintaining and encouraging high standards of quality care. A 1990 RAND Corporation study of five companies has indicated that PPOs are more effective in holding down per capita inpatient costs than traditional fee-for-service indemnity plans. Other studies are also indicating that PPOs are helping employers realize significant cost savings in health care claims.

Integrated and Triple-Option Plans: Today, employers are combining and integrating different kinds of plans in new designs in order that managed care plans—not the costlier, unmanaged indemnity or fee-for-service plans—set the standards, rules and benchmarks by which beneficiaries and providers operate. Lower fees and co-pays are incentives used to encourage beneficiaries to stay within the preferred-provider network; the patient may elect a provider outside the network while agreeing to pay more of the cost.

Plans that combine HMO or PPO plan features with a traditional indemnity plan typically include a "gatekeeper" function that is performed by a primary care physician (PCP), selected by the beneficiary, who assumes responsibility for managing and coordinating all required medical services. PCP gatekeepers coordinate care and thus control costs by reducing unnecessary or duplicative services. They also can guide patients in their use of costly specialist care, assuring appropriate use of these services, through their responsibility to manage referrals. Through referrals, the PCP can also encourage patients to use network physicians who have accepted the managed care goals of the plan and with whom the plan has negotiated reduced fees. Most importantly, the gatekeeper improves quality of care for the patient by providing continuity of care that may be lacking when patients self-refer to different physicians. As a key partner in managed care arrangements, gatekeeper physicians are at least as interested as the employer in managing the cost of the entire health program and making it more attractive to all participants.

Integrated and triple-option plans place a high degree of emphasis on freedom of choice and permit the participant to opt for different providers -- inside or outside of the selected network -- at the
"point of service." Integrated plans are already being used by some employers (described in Appendix Two), and will play a major role in cost management in the 1990s.

Prevention

Health promotion and wellness programs have been installed by employers because it is thought such programs reduce costs.\textsuperscript{14} There is evidence that prevention and "wellness programs" can reduce health risk and costs, as savings result essentially from long-term health care practices. Coors Brewing Company in Golden, Colorado found in a 1988 study that health costs for employees in the company wellness program were 13 percent less than other employees' costs, with an estimated savings of $3.2 million to the company. A two-year study by the DuPont Company of its work-place health education program and its blue-collar employees found a 14 percent decline in absenteeism and returned $1.42 over two years for each dollar invested in the program. The most comprehensive program, offered to employees of Johnson & Johnson, found that 40 percent of smokers in their workforce quit, hospital costs dropped 35 percent, and absenteeism declined between 15-20 percent.

While first attempting "the carrot" approach, by offering wellness programs, some employers are considering "the stick": providing disincentives to employees who engage in unhealthy activities. For example, a few employers have begun to require employees who smoke to pay a larger percentage of their health care premiums. As more Americans quit smoking and improve their nutrition and exercise habits, the quality of health is almost certain to improve.

THE FUTURE OF MANAGED CARE PROGRAMS

Managed health care programs mean more and more consumers will make choices within constraints and perhaps pay more through cost-sharing. To be effective, managed health care must place constraints on providers and consumers in delivery and financing systems, in imposing disincentives for unnecessarily costly use of medical resources, and in rewarding the making of efficient choices. Of course, more information in more hands is needed to make such choices, and efforts are underway to collect and disseminate such information.

Local market health care coalitions, with strong business leadership, are also working to improve quality care and costs through partnerships.
No one approach will provide an overall solution; flexibility is producing a wide array of
techniques that can be altered and applied as appropriate efficient choices. If permitted to expand
and evolve, managed care will be a critical element of reform to America’s health care system.

Above all, success in managing health care costs will mean that all participants in the system --
consumers, insurers, providers and payors -- must work together. Public and private payors,
i.e., government and business, must form a partnership to exact cost savings in the nation’s
health care system, and sustain that effort for the long haul.

Managed health care programs, over time, will improve as advances are made in these areas:

- Increasing UR effectiveness, especially in the areas of ambulatory care, and mental health
  services where costs grew by 27 percent between 1987-1988 -- increasing faster than any
  other health care costs.\(^{15}\)

- Growth and sophistication of integrated health care plans.

- Greater support of prevention and wellness programs.

Public policy initiatives that will also help improve containment of health care costs systemwide are
discussed in the next chapter.
CHAPTER THREE

PUBLIC POLICY ISSUES IN MANAGED HEALTH CARE
AND SYSTEMWIDE COST CONTAINMENT

Managed health care programs will continue to expand and evolve in the next several years. But employers cannot contain costs by themselves. It is clear from past efforts to contain costs that no single, stand-alone solution will work; instead, many tactics are required. Above all, the responsibility for containing costs must be shared by all players in the health care system.

A sustained strategy to contain costs must resolve the problem of millions of health care dollars leaking out of the system, i.e., money wasted on practices and treatments that are unnecessary or that do not contribute to improving anyone's health. Huge sums spent on high malpractice premiums and administrative costs, as well as the inefficiencies of cost-shifting, swell and shift costs from those who won't or can't pay to those who do. Millions of dollars are thus diverted, driving up the effective price of health care for private payors.

Millions are wasted on unnecessary care. Ending or curtailing defensive medicine, expanding preventive care and wellness programs, and expanding the provider's knowledge -- and the consumer's understanding -- of the effectiveness and appropriateness of a wide range of medical procedures will help reduce these wasted resources. Much of these wasted dollars result from over-capacity and a refusal to better match the supply of medical resources to the real needs in our health care system.

Because the third-party payment system has separated much of the cost and delivery of care in the public mind, consumers too often don't consider cost as a factor. Only 21 cents of every health care dollar spent is an out-of-pocket expense. Americans have a huge appetite for expensive, highly intensive and technical care. Since most of this is paid for indirectly, there is no clear financial incentive to let cost-effectiveness enter into the selection of services or service providers.

Managed health care programs attempt to deal with many of the problems associated with waste in the health care system. Meaningful, long-term cost containment will require that patients, providers, insurers, and employers work together in a committed, sustained fashion. The government has a unique role as a major payor, and also in the public policy area, to act as a catalyst, a facilitator, and a team player.
The Association of Private Pension and Welfare Plans endorses cooperative action with, and leadership by, the federal government in these areas:

1. Medical Malpractice Reform

Each year millions of dollars are wasted when physicians practice defensive medicine. They often perform unnecessary tests and procedures to avoid any possible accusation of negligence, and they purchase costly malpractice insurance to protect themselves in the event of a lawsuit. Awards in malpractice cases have soared, some believe well beyond reason. The correspondingly high malpractice premiums distort the distribution of health care dollars because the costs are passed on to all patients. Defensive medicine does not increase the quality of health care received, and can actually lessen the quality of care. Powerful forces continue to resist change in this area, but change is necessary.

Some of the reforms proposed to deal with this spiraling cost inflation have been:

- mandatory periodic payments for awards of future damages exceeding $100,000,
- reductions in awards for compensation received from other sources,
- limiting awards for non-economic damages to $250,000,
- modifying the statute of limitations for malpractice cases,
- implementing a no-fault insurance system similar to workers' compensation,
- replacing the tort-jury trial system with state agencies authorized to review claims and determine awards,
- permitting adherence to established practice guidelines by physicians as an effective defense to a malpractice claim, and
- limiting attorney contingency fees.

2. Insurance Market Reform

Important reforms, like those promoted by the insurance industry itself, would improve the small business market which is the most problematic area for affordable coverage. In March 1990, the
Health Insurance Association of America (HIAA) unveiled a plan to help continue coverage of small employers, limit new pre-existing condition restrictions when changing insurance carriers, curtail premium increases, and create a privately funded and administered reinsurance mechanism for high risk persons. Connecticut recently approved reforms modeled after the HIAA proposal. Other states are considering similar proposals.

The APPWP endorses these reform efforts.

Some have argued that the administrative costs of our health care system are too high, and therefore should be reformed and simplified. While it is true that these costs exceed those of most other nations — most of which have nationalized, one-payer systems — this charge is misleading. Costs for insurance companies to administer health care plans in the U.S. run somewhere between 5-25% of premium, not the 40% some contend. It is also true that the percentage is higher for small plans — but this distorts the actual experience of most plans. Comparing the administrative costs of our flexible and pluralistic system with those of other nations — especially those that deliver a lower level of services — is not an easy task. Reforms in the way insurance can be provided to small groups and individuals along the lines recommended by the HIAA will help reduce administrative costs.

3. Physician Payment Reform

Physician payment reform has already become a reality in the public sector, as discussed in Appendix Two. Beginning in 1992, changes in reimbursement of physicians under Medicare will place greater value on primary care and much less value on many surgical and specialty procedures.

Similar reforms are under discussion by sponsors of private sector plans. In part, these initiatives respond to a fear that physicians may attempt to recoup "lost" Medicare income by increasing the cost and/or volume of services provided to privately-insured patients. On its own, however, the concept has merit, applied also to all providers and combined with effective utilization control, as a way to induce the physician community and hospitals to provide more cost-effective care, within a more consistent and national reimbursement system.
4. Outcomes Research and Treatment Practice Guidelines

Insurers and policy analysts are seeking ways to reduce unnecessary care. Because standards vary widely in different areas, it is difficult for utilization management reviewers to categorize procedures as unnecessary. And with little information available on the effectiveness of various procedures, even providers with clear financial incentives to adopt lower-cost procedures are unable to do so. Outcomes research is designed to evaluate the effectiveness — and in many cases the cost-effectiveness — of medical procedures. It tests whether variations in patient outcomes are explained by differences in the system of care and clinician specialty. Outcomes research and the development of practice protocols and guidelines are intended to build the concept of quality into purchasing decisions, as well as eliminate unnecessary procedures.

Physicians and the hospital industry have been working in this area as well. The hospital community's Joint Commission on Accreditation was one of the first in the health care sector to delineate clear quality standards for care. As the industry becomes more competitive, hospitals need data to access their strengths and weaknesses and to demonstrate the quality of their care to purchasers and regulators. The Hospital Research and Education Trust, a non-profit research and development affiliate of the American Hospital Association, has devoted considerable resources to developing a nationwide study in this area.

Outcomes research can also identify "centers of excellence" — hospitals with a much greater than average success rate for treating particular chronic or catastrophic diseases. Rather than encouraging every hospital to invest in the costly advanced technology that such expertise requires, patients can be sent to the identified "centers of excellence."

There is a tremendous need by employers and other payors for sophisticated data on hospital performance. Companies facing skyrocketing health costs and wanting to direct their expenditures to the most cost-efficient providers are developing their own systems for assessing hospital quality. Some employers are using payment systems that reward hospitals that exceed defined standards of appropriateness and quality. A comprehensive, national outcomes research data base would assist these efforts enormously.

Outcomes research will ultimately be used to develop treatment practice guidelines for physicians. Expert evaluations of data provided by outcome studies can provide a powerful tool to help physicians choose among a variety of alternative therapies for their patients. Physicians are barraged with far more raw information than they can absorb and effectively incorporate into their practice. Practice guidelines will, in effect, condense that information and package it in usable ways. Among the groups actively involved in developing practice guidelines are the American
College of Physicians, the American College of Cardiology, and the Council of Medical Specialty Societies. The Agency for Health Care Policy and Research, in the Public Health Service, is also involved in developing such information.

Treatment practice guidelines will reduce costs not only by decreasing unnecessary care, but also by reducing defensive medicine. With the guidelines, physicians should no longer face the likelihood of being charged with improper care by physicians in other specialties or other regions simply because of practice differences. For that reason, some have suggested that outcomes research and guidelines be first directed at those areas of medicine subject to the most frequent litigation.

5. Dissemination of Information on Effective Care

The information already being produced by outcomes research and effectiveness data and analyses are not being adequately disseminated. There is no organized method for getting it to practitioners, patients, and purchasers of health care. The Health Care Financing Administration has begun to develop avenues of dissemination, as have Pennsylvania and other states. However, national leadership is needed to coordinate and accelerate these disparate efforts. One proposal has been the creation of a new federal agency, a National Institute of Effective Medical Care, to coordinate the entire body of outcomes research and medical technology assessment.

6. Preventive Care and Wellness Programs

While estimates vary widely on the amount of money preventive care could save by reducing individuals' need for more expensive care at a future time, the savings potential is undeniable. This is an area in which public education is critical because, unlike other areas of medicine, preventive care is aimed at predominantly healthy people.

While the private sector is working to promote public awareness of the value of preventive care, the federal government spends a very tiny portion of its health care budget (less than one percent)\(^{16}\) on prevention. Health promotion programs are far more cost effective than our most sophisticated health care treatments and technology. The federal government, American medical schools, and employers need to make prevention a higher priority. For example, we invested more in the areas of addiction prevention and cancer screening America could save millions of dollars.

Further improvements in the environment, such as those to be derived from the Clean Air Act, will also improve the public's health.
7. **Better Matching and Evaluation of Resources and Needs**

More effective governmental policies are needed in planning to influence matching the supply of medical practitioners and facilities to the need of communities. Increased numbers of doctors -- projected to reach 630,000, or 232 per 100,000 Americans, by the year 2000\(^7\) -- and too many hospitals beds, especially intensive care beds,\(^8\) all help to drive up health care costs. Unlike other markets, more doctors, hospitals and equipment do not lower costs and prices. The high cost of technology in health care is in part due to the wide diffusion of expensive machinery -- often driven by competition among hospitals. To recoup the substantial investment in technology by hospitals, the machinery must be used. Over capacity, and the lack of widespread medical and cost assessments of new technologies contribute greatly to rising health care costs. A mechanism is needed to better evaluate and control the introduction of new technology and procedures into our health care system.

As the largest purchaser of health care, the federal government must be active in the area of technology assessment, and influence the matching of medical resources -- physicians, hospitals, equipment -- to real needs of the population. Employers are anxious to cooperate.

8. **ERISA Preemption, State Mandates and Obstruction of Managed Care**

There are over 700 state mandated health benefits across the land. Many of these mandates are for legitimate and needed care and treatment. Unfortunately, too many mandates are for frivolous or marginal services and treatment. These mandates not only boost health care costs to all payors, but make the price of basic insurance for small employers -- where health care coverage is weakest -- out of reach for too many. ERISA preemption of state mandates, extended to all health plans, would permit more employers, particularly small employers, to provide less costly, more basic health packages which not only expand coverage, but reduce employers' costs and make more apparent the difference in cost between a basic health care plan and a fully "loaded" one.

Many of the same forces behind the proliferation of mandates are at work to undermine employer-sponsored managed health care programs. While it is necessary to assure the qualifications and quality of the managed health care industry, many state proposals go well beyond these objectives and, if enacted, would greatly restrict utilization review and stem the viability of HMOs and PPOs. These measures are usually described as pro-consumer or "freedom of choice," rather than the anti-managed care initiatives they are. Federal preemption of state efforts that would limit employers' ability to offer preferred provider arrangements, and the economic incentives for employees to choose them, is required.
The APPWP endorses policy initiatives that will encourage and sustain managed care systemwide and maintain employer flexibility in providing health care programs for their employees, and also expand efforts that will make beneficiaries more sensitive to the cost of care.

The APPWP opposes taxation of employees benefits and other efforts to restrict employers' tax exclusion for these benefits, as well as initiatives that would mandate minimum or maximum benefits packages. The APPWP believes that such efforts would only exacerbate America's access to care problem.
CONCLUSION

The poet Robert Browning said "less is more," and that too may apply to U.S. health care in the future as effective cost management programs take hold. In recent years we have seen only that "more is more," not necessarily better, and the cost of more is draining our resources. Employer managed health care programs may help us finally contain these costs while at the same time actually improve the quality of health care services delivered.

No one player in the American health care system can single-handedly achieve victory over skyrocketing costs. Policy makers at all levels of government must join as partners with the private sector to contain costs and not just pass them along like the proverbial hot potato. The times demand greater cooperation and collective will by all payors, providers, and consumers to contain costs on a sustained and deliberate basis systemwide. If we are to provide coverage to all Americans, we had better control the health care cost monster now.

We've been at this battle for a long time. Those who think this has been a problem since the 1980s have short memories. In fact, almost every decade since the 1940s has seen average annual real rates of expenditure growth ranging from 5.1 percent to 5.6 percent; the 1960s, the decade in which Medicare and Medicaid were introduced, saw an 8.3 percent growth. Health care cost containment has been a sought after yet elusive goal of U.S. policy makers for over two decades. With the federal budget deficit remaining a serious political and economic issue, the federal government has been more aggressive about containing Medicare costs, but much of these savings have been achieved at the expense of employers and other private payors.

In addition, some deficit fighters are recommending taxing health benefits in an effort to achieve equity and raise revenues. The APPWP, in a recent study on taxing benefits, has shown that the current tax status of benefits has yielded a broad-scale system of private coverage that is cost-effective to the U.S. treasury and overwhelmingly favors low- and middle-income Americans. Precipitous changes in the tax status of health benefits is unwise at a time when we want to expand coverage to the uninsured.

There are some today who question whether we should be alarmed at health care expenditures of 11-20 percent of GNP — because they say, as societies become wealthier and more sophisticated they demand more health care, and therefore there is no magic to any figure as a limit to spending. However, the U.S. commits considerably more of its economy to health care than any of our major trading competitors and we do not have a demonstrably healthier population as a result.
Some employers believe that as health care costs ensnare more of corporate profits each year, U.S. industries are at a competitive disadvantage in international markets.

The solutions to our problems probably do not lie outside the U.S.A. While we can learn much about how other nations deliver universal health care for less, most countries learn much more from us about medical research and technological advancements, and are beginning to study our experiments and innovations in cost-effective delivery of medicine. The federal and state governments are jumping on the bandwagon and exploring incorporating many private sector managed health care initiatives in Medicare and Medicaid. Our health care system is uniquely American and the solutions to our dilemma should also be our own.

State governments are taking the lead today in crafting innovative programs to expand coverage and control costs. There is concern, however, that short-sighted pressure, especially at the state level, may thwart or frustrate private managed care activities. Governments at all levels must instead encourage innovative and flexible programs, make outcomes research a higher priority, reform medical malpractice, and work with the private sector to effect other meaningful reforms in the U.S. health care system. Our challenge is to develop the political will to bring about these needed changes.

Association of Private Pension and Welfare Plans
Washington, D.C.
January, 1991
ENDNOTES

1. Unless otherwise indicated, data cited in this paper are from the U.S. Health Care Financing Administration (HCFA), Department of Health and Human Services.


4. Uncompensated community care in community hospitals totalled $9.7 billion in 1987, according to the American Hospital Association.

5. HCFA, U.S. Department of Commerce: In 1988, employers paid $133 billion in (non-Medicare) medical care benefits of the $540 billion American health care bill.


7. According to the Bureau of Labor Statistics, HMO usage grew from 3 percent of full-time workers in 1980 to 19 percent by 1988. BLS data also indicate that PPO participation grew from 1 percent in 1986 to 7 percent in 1988. Over 70 percent of Americans with employer-sponsored plans have one form of managed care or another in 1988, according to the Health Insurance Association of America.


10. The RAND Corporation.


12. Group Health Association of America.


15. Employee Benefit Research Institute.


17. Dr. Alvin Tarlov, Graduate Medical Education National Advisory Committee, 1984. Dr. Tarlov estimated that this number was 70,000 more doctors than needed.

18. According to Joseph Califano, intensive care beds have been added at an average rate of 2,500 per year since 1958. These beds comprise 7 percent of all beds but account for 20 percent of all hospital costs.
APPENDICES

APPENDIX ONE:
Government Approaches to Health Care
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APPENDIX TWO:
Private Sector Managed Health Care Programs
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APPENDIX ONE

GOVERNMENT APPROACHES TO HEALTH CARE

In seeking solutions to problems of spending and access in the U.S. health care system, policy makers have looked abroad at health care systems of our chief trading partners who spend less per capita as a percentage of GNP than the U.S. while providing nearly universal coverage. These investigations are enlightening and useful. Included in Appendix One are discussions of the health care systems in the United Kingdom, West Germany, Canada and Japan, as well as an examination of federal health policies in the U.S.

We in the U.S. have much to learn about how health care is delivered in other countries, but certain cautions must be acknowledged in any comparisons of health care systems across borders.

The difficulties of direct comparisons lie in the sometimes subtle yet compelling distinctions in economic and population demographics, cultural attitudes toward government and health care, treatment practices and patterns, and even the degree of medical malpractice litigation. Data are not easily comparable for a variety of reasons and performance outcomes cannot be easily evaluated. For example, we may perform certain surgeries more often than in another country, but with differing outcomes. High technology equipment may be less available in some countries, but there is no agreement on the appropriate ratio of such technology per person. Data on waiting lines for surgery and availability of high technology equipment generally are not available. No matter how admirable and effective one nation's health care system might be, such systems are not easily transferred to another country's population and system of government.

The first essay in Appendix One is on how the U.S. government has attempted to contain health care costs over the last twenty years. Next are brief overviews of health care systems in the United Kingdom, Canada, Germany, and Japan.
TOTAL HEALTH EXPENDITURE AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT [GDP], PER CAPITA HEALTH SPENDING AND PERCENT OF HEALTH EXPENDITURES PUBLICLY FINANCED

(All figures are in percent except per capita)

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Per Capita Health Spending, 1987

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Sources: OECD, Health Data Bank.
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**Average Length-of-Stay in Inpatient Care Institutions**

**Selected Years, By Country**

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*All data, except as noted, Organization for Economic Cooperation and Development: Health Data File, 198*

(1) Not available
(2) Source: American Hospital Association average length of stay in U.S. community hospitals
## Selected Medical Technologies

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Ratio of U.S. to:

Source: D. Rublee, *Health Affairs* (Fall 1989)

Units per million persons
PART ONE

THE U.S. GOVERNMENT'S EXPERIENCE IN HEALTH CARE COST CONTAINMENT

The federal government is the largest payor and sponsor in our health care system. Through the Veterans Administration, Defense Department systems for the Uniformed Services and other agency programs, the U.S. government has been an influential player in health care for a long time. But with the creation of the Medicare and Medicaid programs in 1965, a major new chapter in America's health care story began. The federal government (and the taxpayers) have faced in Medicare—and, some may argue, created or inflamed—a staggering growth in costs.

Medicare is by far the largest health care program and acts like the proverbial 500 pound gorilla in the U.S. health care jungle. In its first full year, 1967, Medicare cost $4.7 billion, less than three percent of the federal budget. In 1990, Medicare costs around $85 billion and represents 8.6 percent of the federal budget.

Originally, hospital reimbursements were cost-based, retrospective payments for "reasonable costs" of treating patients. Physicians were reimbursed for "usual, customary and reasonable" fees. The policies were intensely inflationary, provided no incentive to provide or demand cost-efficient health care services and were biased toward expensive acute-care, front end coverage. A combination of heated health care inflation in the 1980s and the soaring budget deficit drove Congress to squeeze Medicare and seek ever more effective cost containment strategies.

This section will focus on the government's efforts in the mid-1970s to control all prices, including the health care sector, as well as cost-containment measures enacted under Medicare through today.

Wage and Price Controls 1971-1974

The Federal Government undertook its first main venture into private and public health care cost containment in 1971 when, on August 15, President Nixon announced a freeze on all wages and prices, economy-wide. Simultaneously with that announcement the Cost of Living Council and the Price Commission and Wage Board were set up to administer the program. Phase I of the freeze on wages and prices lasted 90 days.

To handle the rather unique features of the health care industry, a Health Services Industry Committee was established with representatives from consumer, provider, labor, and other
for hospital payments. In other states, other payment methodologies for hospitals were employed; however, the comparability among payments from various payors was maintained.

The experience of different states with all payor systems varied considerably. In Massachusetts the all payor experiment was terminated with the state owing the federal government several million dollars for failure to comply with the provisions under which the waiver had been granted. All payor waivers were granted by the federal government with the stipulation that they would save Medicare funds compared to what Medicare would have paid absent the waiver. A reduction in the rate of growth of Medicare hospital expenditures of two percent less than the national average was a condition for granting the waiver.

Massachusetts and New York remained under the all payor system for only a short period of time since they found it could not restrain the growth of hospital payments. Other states such as New Jersey and Maryland continued the waiver for a longer period of time. Maryland is the only state that currently has an all payor system for hospitals.

All payor systems produced mixed results. States such as Maryland that have had success with all payor systems have reinforced the system with a rigorous state oversight mechanism.

Health Planning Law

Reducing the number of hospitals, and hospital beds, was the goal of the federal Health Planning Law of 1974. Under this law, Health Systems Agencies were established in each state with the purpose of reviewing all capital expenditures by hospitals that were in excess of $100,000. In addition, requests by hospitals for the expansion of existing services or the introduction of new services had to be approved by the health systems agency in order to be eligible for Medicare reimbursement. In order to get a certificate of need (CON), hospitals had to show that such expenditures and expansions filled a community need. All health systems agencies within a state reported to a single state health coordinating council. Decisions of the health systems agencies were subject to review and could be overturned at the state level.

The effect of health systems agencies in accomplishing their stated objectives was uneven at best. While some constraint in supply did occur, various political and provider forces in communities often intervened to keep excess beds open or to approve unnecessary expansions. In some states, rigorous standards were applied whereas in other states, virtually all requests from hospitals were approved.
Funding for health systems agencies at the federal level was withdrawn in the early 1980s. Some states continued their state planning activities with state revenues. However, many states terminated their state planning authorities.

The record of the Health Planning Law as a cost control measure is questionable. The period when it was in operation witnessed one of the fastest growth periods of the investor-owned hospital industry in America. Supply constraints did not control outpatient and ambulatory care facilities and thus there was a significant expansion of such facilities during this period, and inpatient health care costs continued unabated. Yet in some states, after CON programs were eliminated, costs surged. A better matching of a locality's needs to its supply of hospital beds, technology, and physicians is still needed.

**PPS Hospital Payment System**

In 1983, the Prospective Payment System (PPS) for hospitals was enacted and with it, a basic philosophical shift in Medicare reimbursements. PPS consciously attempted to move Medicare from an inflationary and wasteful reimbursement system to one that rewards the efficient provider. Under this system, which is currently in place in a more refined and sophisticated form, hospitals were paid on the basis of a cost per diagnosis. Each hospital admission is broken into one of 468 (later enlarged to 477) diagnostic-related groups (DRGs) and the average costs for that category were established based on previous hospital cost experiences. The PPS introduced product-line accounting into hospitals and differentiated hospital outputs into more refined and meaningful groupings. Costs for comparable procedures now could be compared among hospitals, which could better and more precisely determine services with a cost advantage relative to competitors. A Prospective Payment Assessment Commission was established to advise Congress on appropriate annual updates in hospital rates.

In calculating base costs for hospitals, a miscalculation in excess of a billion dollars was made. This excess payment was, however, squeezed from the system in subsequent years by providing hospitals with minimal annual updates. Under the PPS, hospital rates, beginning in 1985 when the program was fully implemented, were severely restricted by the Department of Health & Human Services (HHS). Reacting to provider complaints, Congress in 1987 took over from HHS authority for determining updates. The Department's role was limited to one of making recommendations on PPS annual updates.

Although not originally intended as such, the PPS has evolved into an administrative price control mechanism that has proved very effective in holding down rates of increase in hospital costs to Medicare. DRGs have shortened hospital lengths of stay and admissions dramatically for
Medicare. But DRGs have also led to changes in the definition of diagnoses, leading to higher costs where extended confinement could be justified and early discharges when allowances had run out. Since 1985, the Medicare Part A program rate of increase has been relatively level. More and more hospitals with excess capacity are finding it difficult to stay in business. In FY 1989 an average of almost two hospitals per week closed in the United States, but hospital occupancy rates for 1988 were only 69.2 percent. However, because more care is pushed into outpatient settings, physician Part B costs have risen dramatically.

The PPS has been particularly difficult on small, rural hospitals which experience wide fluctuations in occupancy. Recognizing this, Congress established separate rates for urban and rural hospitals. However, even with this refinement, rural hospitals still have been hard-pressed.

**Physician Pay Reform**

In 1989, Congress took a bold step to constrain and reallocate physician reimbursement. Since the Economic Stabilization Program, little effective action has been taken to restrain physician costs, yet as a percentage of total health costs, these have increased much faster than hospital costs in recent years. In response, HHS allowed no percentage increase in physician Medicare fees in each budget year from 1985 onward for three years. This did little, however, to retard the growth in physician health care costs. As was evidenced during the Economic Stabilization Program, the volume of services increased (including ancillary services) so that in 1987, even with Medicare permitting a zero percent increase in fees, physician payments still increased 17 percent.

In the 1990 budget, Congress enacted a number of policies designed to restrict physician health care costs under Medicare. Although not yet implemented, it is likely that together they will exert a significant impact on physician cost increases under federal entitlement programs. The reforms are also intended to emphasize primary care over high-cost specialty care providers.

The new physician payment reform has three parts: a resource-based relative value system (RBRVs) to control rates by compensating more equitably different types of physician services; a volume performance standard to control the rate of increase in physician expenditures for unnecessary increases in service volume; and balance-billing limitations to constrain the amounts by which physicians may bill patients for costs exceeding Medicare allowable charges. Other changes would prohibit physicians from referring patients to laboratories in which they hold a financial interest. These actions, recommended by the Physician Payment Review Commission, established to advise Congress on physician payment policies will, coupled with HHS' systematic reduction of payments for twelve overpriced procedures, undoubtedly restrict the cost of physician services under Medicare. There is widespread concern among private payors that, as in the past,
these costs will be quickly shifted by physicians who will charge private employers and others more, compensating for revenues "foregone" due to Medicare program changes.

Also included in the 1990 budget was Congressional approval for $32 million for medical outcomes research in FY 1990, a fourfold increase from 1989, and an amount that will increase steadily to $185 million by FY 1994. It is widely believed and hoped that development of practice guidelines, based on outcomes research, will promote costs savings further.

**CONCLUSION**

Numerous other, less far reaching, Federal cost control measures have been implemented over the years, targeted at specific components of the healthcare industry with mixed and unclear results.

The overall success of Federal health care cost control measures over the years has been spotty, at best. No sustained, system-wide controls have been put into place for very long. Pressure by special interests on the political system undermined comprehensive control and planning systems. While much has been learned about what works and what does not, whenever Medicare has succeeded in holding down its costs, costs have shifted to private payors; savings have not resulted system wide. There has been an estimated shift of 20-25 percent of inpatient charges to private payors.

While the future role of the federal government is not entirely clear, certain things are. The government has demonstrated a lack of political will to get at the underlying problems of health care cost escalation. The private sector, in establishing and refining managed care, is going after some of the root problems. No doubt efforts to constrain Medicare costs will continue, and costs will be shifted to the private sector.

The government must become more active in containing all costs, especially if federal policy makers move to expand access and provide a new long-term care program. It is not now clear whether the government is ready to play a major cost containment role systemwide.
## Outlays for Major Spending Categories for Selected Years in Nominal Dollars, and as a Percent of GNP and Budget

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<tr>
<th>Year</th>
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### Sources
- U.S. Department of Health and Human Services

## Medicare Benefit Payments (In Billions) and Annual Percent Change, Selected Years, 1966-1987

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<th>Year</th>
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### Sources
- Congressional Budget Office
PART TWO

THE UNITED KINGDOM HEALTH CARE SYSTEM

The National Health Service

The National Health Service (NHS) was set up in the United Kingdom in 1948 with the aim of providing free comprehensive medical service. It is administered by the Department of Health and Social Security through 14 district health authorities (DHAs). The cost of the NHS is provided by the government from general taxation and in 1987 was estimated to be over $31 billion.

Today, every UK resident has access to free hospital and specialist services as well as general practitioner treatment. A small charge is levied for items such as drugs and medicines; eye glasses and dental treatment are also subsidized. The NHS provides immediate care or emergency and maternity services and mental health but persons may have to wait months or even years for treatment of non-urgent surgical conditions in an NHS hospital. The NHS still enjoys wide popular approval with the public, although the generally accepted level of care may differ from that in the United States.

Private Medical Treatment

Private treatment has always been available for such things as a private room, and to ensure the patient's, or the physician's, choice as to who will provide his treatment.

In the past many people have felt that it wasn't worth spending the additional money for these particular advantages. It is not possible for an individual in the UK to opt out of the NHS and the health tax is still collected from individuals even though they may prefer to be a private patient at their cost in the event of illness.

Lately, however, because of the increased number of people waiting for treatment, many Britons have felt the additional payment required to secure private facilities may be worthwhile, since private treatment can be arranged quickly and at a time to suit the individual.

Private medicine operates within and outside the NHS. In 1987, private hospitals and medical care comprised 13.1 percent of total health care expenditures in the United Kingdom. NHS hospitals throughout the country provide more than 3,600 beds called "pay beds" which can be used by
private patients on payment of the appropriate fees to both the hospital and the specialist looking after the patient. In addition there are over 10,000 beds within private hospitals which have been built and are administered by organizations totally separate from the NHS. These private hospitals in the main are not able to provide emergency services nor maternity services but can provide first class attention for routine surgery at all levels.

The cost of private medical treatment is relatively expensive in the UK and this has led to the rapid growth of private medical insurance over the last few years. More than 5.7 million people representing 10 percent of the UK population are now covered under some form of private medical insurance, more than 40 percent of these people have joined within the last two years. Twenty-four percent of medical insurance premiums are wholly company-paid and another 14 percent are partially paid by employers. Private health care now ranks among the top three most popular employee benefits.

Costs

The UK devotes a smaller percentage of GNP (6.1 percent in 1987) to health care expenditures than most OECD countries. Comparable 1987 figures for the U.S. are 11.2 percent, France 8.6 percent, Canada 8.4 percent, Germany 8.2 percent, Australia 7.1 percent, Japan 6.6 percent, with an OECD mean (including all 24 countries) of 7.3%. Since most health care expenditures in the UK are publicly financed (96.9 percent in 1987), government policy plays a major role in determining the amount spent on health care. The Thatcher government has actively restrained the growth of the NHS and has been able to keep the real rate of annual increase in NHS costs to 1.6 percent during the period 1975 to 1986 when U.S. costs soared.

However, there is widespread recognition that the NHS is insufficiently funded. Sixty-nine percent of Britons in a recent survey indicated that their health care system was in need of fundamental changes. It is estimated that there is a list of some 800,000 people waiting to receive hospital treatment for non-urgent surgeries. Waiting lists for operations such as hip replacements, hernias, and varicose veins can be as long as two or three years.

The inability of the NHS to meet demands has become the focus of public and political attention. While new technology is introduced in the U.K. as easily as in the U.S., it may not be as widely available due to NHS budgetary constraints. As coverage in private facilities grows and as more private hospitals purchase high tech equipment, access to high tech care is growing.
Over the next decade the pressures on the NHS will only increase as a result of demographic changes from a maturing population, the development of new, expensive technology, and new epidemics such as AIDS. For the present, long term care in the U.K. is viewed as the responsibility of the NHS and it is unlikely that private insurance products will be available any time soon.

Cost Containment Efforts

In January 1989 the British issued a “white paper" which proposed a restructuring of the NHS by applying "a free market philosophy." Under this plan, DHAs which are not monopoly suppliers would instead become purchasers of services on behalf of the people they serve. The DHAs would be free to seek the highest quality care at the best possible price outside their district, and even outside the NHS. Regions would receive budget allocations based on population, adjusted for age, morbidity and other demand factors.

The "white paper" also proposed that hospitals be allowed to opt out of district control and be free to set their own pay scales and compete for customers. If a patient crossed district boundaries to obtain treatment, so would the fee, giving the hospitals some incentive to treat as many patients as possible.

In addition, large group general practitioners (GPs) would be offered budgets to purchase services beyond primary care such as hospitalization. GPs would also be encouraged to compete for patients by changing the payment so that 60 percent rather than 40 percent of family doctors’ incomes would come from capitation fees.

It has also been suggested that the private sector be used to reduce the strains on the NHS and promote efficiency by seeking ways to motivate individuals and employers to provide health care. For example, it has been suggested that tax relief be given to the elderly for the purchase of private insurance, and there has been talk about the possibility of allowing employers to "contract-out" of the NHS in return for a reduction in their social security contributions.

UK insurers are actively engaged in cost containment so as not to price themselves out of the market. They have helped focus their larger corporate clients’ attention on cost containment through the introduction of experience-rated subscriptions, more detailed claims reports to make it easier for insurers to review claims to determine the reasonableness and the necessity of treatment, and thus allow purchasers to become selective to the point of actively excluding hospitals or specialists who clearly charge in excess of the norm. There is also great interest in U.S. cost management innovations.
Emphasis is being placed on the design of private plans, and features such as excesses (deductibles) and copayments are being introduced. One insurer has offered discounts of 20 percent of premium if the patient accepts to pay the first 60 pounds sterling (around $104) of eligible treatment. Another insurer has offered companies with 50 or more employees the opportunity of excluding pre-existing conditions during the first two years of coverage in return for premium savings of about 17.5 percent. Premium discounts for non-smokers are also available.

Another feature has been the introduction of "banded plans" which enables a company to reduce medical insurance costs while still providing employees with a full refund for the cost of private treatment. Employers can select the particular level of coverage appropriate to its own needs and therefore give it greater control over costs. All acute care hospitals are grouped into one of four bands according to the total cost of hospital treatment they provide. The employer then selects the band or group of hospitals within which its employees will receive treatment and pays the appropriate premium. Many of the higher priced hospitals, such as the London teaching hospitals, have been multi-banded so that subscribers to less expensive bands can still make use of the highest quality care facilities. The employees retain the right to use the higher-priced hospitals or bands but are then required to pay the difference between their actual bill and the out of band benefits stated in the policy. Outpatient surgery is paid in full regardless of the band selected. Hospital banding also puts pressure on hospitals to keep charges down by reducing the number of patients eligible for high cost services.

Private insurers are also being urged to encourage treatment in non-traditional and less costly settings by modifying plan design to include coverage for hospice care and by providing full reimbursement for out-patient or "day care" surgeries.

CONCLUSION

The problems faced by the NHS will only intensify in the near future as birth rates decline and longevity improves. As cost pressures force the NHS to reduce or cut back services, the shift to private health care can only increase.
PART THREE

GOVERNMENT HEALTH SERVICES IN CANADA

BACKGROUND

The provision of health services in Canada is a provincial responsibility. Consequently, the Government Health Services program is made up of 10 separate provincial plans. The federal government contributes close to 50 percent of the costs on the condition that the provinces meet criteria regarding administration by a public authority, comprehensiveness of services, universality of access, portability among provinces and accessibility on uniform terms for all residents. The federal government's contribution comes out of general taxation; each province raises its share of the cost in its own manner, being one or a combination of general taxation, payroll tax and specific premium. Membership in most plans is automatic or compulsory, but is voluntary in three provinces.

Besides universal coverage, perhaps the feature of the Canadian health care system most popular among some U.S. health policy students is the means by which spending is controlled: global budgeting. The provincial governments determine an annual allocation of spending for each hospital. If exceeded, the province pays the difference but the amount is deducted from the hospital's budget in the following year. In addition to global budgeting, costs are controlled by the provincial governments through regulation of hospital capital expenditures. Physicians' fees are negotiated by the government and medical association in each province. Finally, because the Canadian system is a one-payer system, administrative costs are lower; Canadians spend about $15 per person while the U.S. spends around $106 a person. For those south of the border enamored of Canada's global budgeting, others decry the system's need to ration care and services resulting in waiting lines for much surgery, equipment shortages, and contentious clashes over wages and fees. Critics of the system have long held that the program inherently encourages greater demand for services with little constraints other than those imposed by global budgeting.

The provincial plans, though not identical, are very similar. The services covered, provided they are medically required, include hospital care, doctors' fees in and out of hospital, diagnostic services, obstetrical and psychiatric services, drugs in hospital and certain paramedical services. Dental services, vision care and prescribed drugs are not covered, although most provinces pay the cost of prescribed drugs for senior citizens and some provide dental care coverage for children. Each patient has complete freedom in choosing a doctor, but treatment by a specialist may in certain circumstances require a referral from the general practitioner. Few provinces pay
premiums on employees, but where they do, employers tend to pay all or part of the premium which in turn is taxable to the employee.

Hospital Services

Universal hospital coverage was introduced province by province in the years immediately following enactment in 1958 of the federal Hospital Insurance and Diagnostic Services Act. Hospitals have continued to be privately owned and operated as before and are allocated funds through global budgeting. Government plans provide virtually the same coverage as the previously influential Blue Cross plans, except that all dollar maxima and limitations on length of stay were removed, and all inpatient and outpatient services are covered.

The plans cover care in a standard ward. Private accommodation is paid if it is essential for medical purposes. Charges for semi-private and private wards are paid by the patients (which can be covered by private insurance), with the hospital and government sharing the proceeds. The hospital income from this source is used to purchase equipment and provide facilities not covered in the approved budget.

Medical Services

Medical care coverage was introduced following the enactment in 1968 of the federal Medical Care Act. Prior to the government plan, there existed in virtually all provinces of Canada doctor-sponsored prepaid medical care service plans, controlled by the medical profession, which underwrote a large portion of the costs of medical care. In return for monthly contributions, the plans paid participating doctors a specific fee for each medical service rendered to a subscriber which was accepted as payment in full.

It was generally believed that if the federal and provincial governments were to obtain the agreement of the medical profession to participate in their plans, the doctors would have to be reimbursed on a "fee for service" basis as they preferred. During the extensive dialogue over several years between the federal and provincial governments, the medical profession increased its fee tariffs several times in order to develop a fee schedule they could accept as a basis for negotiations and which would also serve to cushion or absorb normal inflationary costs.
COST ESCALATION AND CONTAINMENT

Hospitals

The overall costs of hospital care increased immediately following the introduction of the provincial plans. Many hospitals had been operated and staffed by members of religious orders who had previously donated their services and now felt they should be paid the same as others. Nurses, who had previously been underpaid as compared to other professionals, demanded increased remuneration. Many hospitals which had been coping with obsolete equipment demanded more modern equipment and facilities. However, there was no significant increase in hospital admissions as virtually no one in the past had been refused hospital care.

A patient can be admitted to a hospital only on the signature of a doctor. Control of hospitals costs has therefore to be exercised by reducing supply and the cost of providing care. Global budgeting led to more efficient operating procedures, the avoidance of wasteful duplications of services, and the use of the right person for the right job so that services are not provided by over-qualified persons.

By dedicating certain hospitals for specific specialties, services have been reduced and the quality of care has been improved. Instead of every major hospital undertaking, say, open heart surgery, this service is now available only in one hospital in a particular geographical region. Suburban and rural hospitals continue to provide all types of service, but a patient in an outlying area requiring specialist care not available locally will be flown to the nearest specialist hospital.

Lengths of stay in hospitals are roughly double those in the U.S., but are not directly comparable, as some provinces assign 10 percent of beds for what might be termed chronic care for the aged. Hospitals have an average occupancy rate of about 95 percent.

Some hospitals have not been able to live within their budgets and some have outstanding deficits which will have to be paid off by the hospital raising money from charitable donations or providing non-medical services, such as laundry, to commercial clients not connected with the hospital. As costs rose over the years, controls had to be introduced.

Health care costs in Canada have been stable until recently; they are now increasing at a rapid rate. In 1975, health care costs represented 7.2% of GNP or $12 billion; in 1985, though well below the U.S., that number reached $39 billion or 8.6% of GNP. As hospital and other institutional care costs continued to rise over the years and as such costs represent about
two-thirds of the total cost of the government health services plans, the government initiated measures to clamp down on health care cost growth.

The federal government, tired of paying for plans whose operation and control were determined by the provinces, began to limit increases to their own formula that recognized general inflation rather than actual costs. In the last budget the federal government arbitrarily limited its increase to the wealthier provinces to 5 percent and gave warning of lower future increases. These in turn gave rise to lawsuits by three provinces, claiming that the federal government could not unilaterally limit their increase. Rates have been indexed since 1984 and the federal government has recently proposed to freeze rates.

As a result of the cost controls, some hospitals have had to close beds, which has caused delays for non-emergency or elective surgery requiring hospital care. Even with the closing of these beds, the ratio of acute hospital beds to each 1,000 of population is only slightly lower in Canada than in the U.S., as such ratio was much higher in Canada than in the U.S. at the inception of the Plans.

Many surgical procedures are now being performed on an outpatient basis with no loss of quality of service, but with substantial cost savings. Sophisticated and modern diagnostic aids, such as lithotriptic and magnetic resonance imagers, are in short supply as compared with the U.S., which again leads to delays in service. For example, there are 31 cardiac catherization labs per 816,000 people, compared to 1,500 labs in the U.S. for 166,000 people; four lithotripters for every 6,325,000 Canadians compared to 228 for every 1,096,000 Americans; twelve magnetic resonance imagers for every 2,108,000 Canadians compared to 1,375 MRIs for every 182,000 Americans. There is only one CAT Scanner is all of Newfoundland. The shortage of physiotherapists and other paramedical professionals in the hospitals due to budget cutbacks has led to the establishment of some private facilities; services provided at those facilities are not covered under the government plans.

Private health care insurance for services covered by the provincial health services plans was banned at their inception. Insurance was, and still is, permitted for such health care costs as dentists, prescribed drugs, private nursing, prosthetic appliances, etc. Some of these private insurance plans cover physiotherapy services and laboratory tests, so that this type of service would be covered at private facilities. More than 95 percent of employers provide some form of supplementary insurance plan.
Medical Services

Wages of nurses and other hospital workers are effectively controlled by the provincial governments. Contentious negotiations have on occasion led to strikes and the closing of hospitals for other than emergency care. The medical profession in some provinces has had difficulty in negotiating fee schedule increases. For example, after taking inflation into account, the real income of doctors in Quebec decreased by about 19 percent from 1970 to 1976.

To offset this reduction in real income, the doctors in some provinces began billing patients for the difference between what the provincial medical association believed was a reasonable fee for the particular service and what the government paid the doctor. "Extra billing" was claimed by the doctors who used it as a fair way of subsidizing the cost of the government medical services plan with private funds from their patients. They also claimed that they did not submit a bill for an additional fee to any patient financially incapable of paying it. The federal government claimed that this practice was contrary to the philosophy of universal access and said it would reduce its contributions where the practice continued. As a result, extra billing has virtually disappeared.

The Future

The population of Canada is aging, and as the average cost of inpatient hospital care for persons over age 65 is nearly six times higher than the average cost of such care for persons under age 65, future costs are expected to continue to rise. These increasing costs will have to be met by a combination of increasing taxes, more efficient delivery of health care, and longer waiting periods for non-emergency care. Greater emphasis is already being placed on care being provided at home.

More hospital beds may be closed and the supply of doctors reduced by limiting places in medical schools and preventing foreign trained physicians from practicing. Fee schedule increases may be kept below inflation. Certainly, more emphasis will be placed on the prevention of sickness. Some believe that the government may shift more costs onto individuals and employers in the future. While Canadians may begin to consider U.S.-style managed health care, limiting Canadians' choice of doctors would represent a fundamental, and unpopular, change.

Because the Canadian population is sufficiently enamored of its plan, it is unlikely that politicians will be permitted to drastically reduce its benefits. Despite criticisms, the plan has been successful in that it satisfies the needs of Canadians and is acceptable to the majority of health care providers. The culture of Canadians is such that the fear of some reduction in the quality is much less than the fear of having no coverage and having to face the possibility of catastrophic health care bills.

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* Uses United States gross national product (GNP) consumption deflator.
PART FOUR

GERMAN HEALTH CARE SYSTEM

Coverage and Benefits Under Sickness Funds

Compulsory health care—without socialized medicine—has been a major element of Germany since the end of the last century. The decentralized system, covering between 90-95 percent of the population, is built around 1,300 statutory sickness funds, organized on the community, company, and trade and professional levels. Funds exist for others not included in these categories. The insured population chooses which sickness fund to join based on residence and occupation. A small percentage of the population is covered by government-provided programs so that the total uninsured population tends to be 0.3 percent. Sickness funds are government-approved mutual benefit societies; state funds are directed by civil servants, public funds by outside management or the insured individuals, and company funds are directed by worker and corporate representatives.

Membership in the funds is compulsory for all wage-earners and salaried employees earning less than DM 56,700 per year in 1990 (approximately $33,000). Only persons earning above that level of income may join a private health insurance plan although they may join a public plan. Old age pensioners and insured unemployed persons, together with their dependents, receive a subsidy for their contribution and as such have equal coverage. The average contribution payable to local sickness funds in 1989 was 12.8 percent of salary, shared equally between employer and employee, up to the annual upper income ceiling. Pensioners pay an amount equal to half the rate of the normal contribution. When employees earn in excess of the earnings ceiling they can remain covered on a voluntary basis.

All sickness funds provide a statutorily similar benefits package which includes: hospital treatment, surgery, out-patient treatment, pharmaceutical products, family planning, dental care, optical treatment, hearing aids, cash sickness benefits, and maternity benefits, where certain benefits are free of charge (e.g. free hospitalization in a general ward for up to 78 weeks during a three-year period) and other benefits are available only on the basis of cost-sharing (e.g. dental care). All funds pay the same level of fees to doctors and other professionals as set by negotiated agreements between regional associations of funds and provider groups.

Doctors in the German system are divided into two statutory categories: Around 45 percent of doctors are salaried employees of the hospitals where they work; ambulatory physicians are reimbursed on a fee-for-service basis and they do not see their patients once they are
hospitalized. Dentists are under contract to the government health insurance program and, like their physician counterparts, they charge the health insurance fund directly. Patients are generally unaware of the charges: providers bill the sickness funds directly for services rendered. Patients under the compulsory insurance program must go to one of the two nearest hospitals, chosen by the doctor, and pay a contribution, of DM5 per day ($3.00) for the first 14 days of any hospital stay, (to be increased under the new law to DM10, or $6.00 in 1991) toward the first two weeks of a hospital stay. They also pay a modest fee toward prescriptions. Hospital per diem rates are negotiated by each hospital with regional associations of sickness funds under an all-payer system, subject to the approval of state governments, which also must approve and finance capital investments, based on statewide hospital planning.

**Private Insurance**

Around 8.7 percent of the population, mostly individuals who earn above DM 56,700 per year, salaried employees and self-employed people not subject to any compulsory program, are covered by some form of private commercial insurance carriers. Private insurance is also purchased by those in compulsory funds to supplement benefits — such as private hospital rooms — under compulsory coverage or to provide tailor-made products for the voluntarily-insured.

**Cost Containment Efforts**

Health care costs have risen sharply in Germany in recent years; this led to the Health Reform Law passed in January, 1, 1989. Contribution rates were increased and earnings subject to contributions also increased. Considering salary increases and other previous rate increases, contributions have increased sixfold since 1970.

Also included in the reforms were cost containment measures such as incentives for preventive care, some reduced services and reimbursements in fields where medical requirements are allowed, more cost-sharing by patients — especially for prescriptions; home nursing care benefits were added, and some experience rating combined with refunds of some contribution when no medical claims have been filed for a full year is being tried on a trial basis. A new, basic benefit coverage for the working poor — at lower rates — was also included. One result of the 1989 law is increased interest in private, supplementary insurance.

With the reforms effective January 1, 1989, medical cost seems to be better contained, which already resulted in the reduction of contribution rates by some sickness funds or refunds of contributions.
Although budgets, fees and rates are determined at the local level, "Concerted Action in Health Care," created in 1977, is a forum that brings together all stakeholders in the German System to make broad recommendations for the System's future in terms of growth, improvements in efficiency and quality of care, and allocation of resources each year.

Private households in West Germany pay out-of-pocket medical expenses of about 7 percent, compared to 26 percent for Americans. Total social security expenditure (health care, pensions, unemployment benefits, etc.) in Germany represents approximately 30% of gross domestic product (GDP). The compulsory health care related expenditure is 8.2 percent of GDP in 1987.

The Future

No dramatic changes are expected for the German health care system, however, the full, fiscal impact of reunification -- updating former East German resources and coverage of millions more Germans, and growing unemployment -- cannot be known. The aging of the German population (Germany has one of the lowest birth rates in the world), the difficult social problem of taking care of the very old who are not medically sick but require basic care, requires some innovative answers. Compulsory insurance for this type of long-term care has been considered, but the debate is still under way.
PART FIVE

HEALTH CARE IN JAPAN

Japanese Social Security programs provide extensive health care coverage compared to the U.S. Individuals pay only a relatively small share of medical costs. As a result, private medical coverage is limited. Medical contributions have remained stable in recent years in line with the overall cost-of-living, although the aging of the population suggests that higher costs for older people will put pressure on the system in the near future.

Health Care Delivery

There are two welfare plans providing health care coverage for employees and their dependents, and the self-employed and their dependents. Government Health Insurance covers all company employees; participation is mandatory. The plan pays for medical expenses incurred as a result of non-occupational injury or sickness. (Occupational health care costs are provided separately under workers compensation.) Disability income and funeral costs are also covered.

The health care coverage includes hospital room and board, medical treatment, childbirth, surgical operations, supplies of medicines, medical consultation, nursing care and some dental care. It excludes certain types of medicine and nursing and additional charges for private or semi-private rooms. The coverage extends to Japanese employees receiving medical treatment overseas.

Contributions are shared between employer and employee, each paying 4.15 percent of monthly pay, up to maximum of 710,000 yen, or $4,650. Semiannual bonuses are also subject to the contribution requirement -- 0.5 percent from the employer and 0.3 percent from the employee.

Benefits are subject to co-payments: 10 percent employee care, 20 percent dependents' in-patient care, and 30 percent dependents' out-patient care. Maximum out-of-pocket expenses under Social Security is Y.57,000 or $375 per month. For employees whose company participates in an industry association, the maximum monthly out-of-pocket expense may be less -- as little as Y.3,000 or $20 in some cases.

These co-payments are subject to an overall maximum co-payment of 57,000 yen (or $375) per month per illness. The 10 percent employee co-payment was introduced in March, 1984 (dependents' co-payments had always applied), and the co-payment limit has been increased regularly since then.
Private medical coverage takes two forms: Companies may contract out of Government Health Insurance and establish industry associations or their own association with at least 700 employees for insurance. Also, individual and group insurance coverage is available in addition to Social Security.

Several industry-wide associations have been established and provide slightly higher benefits, usually by reducing the employee co-payment. The average individual health care cost net of direct payments is about ¥160,000 (or $1,050) per year; total health care expenditures in 1987 were $23.85 million. In addition, the premiums are experience-related and are often lower than those for Social Security. This presumably reflects the better than average health of employed people. In 1985, average contribution rates were approximately 4.05 percent each for employer and employee.

Individual insurance often provides for the cost of pay beds, i.e., private or semi-private rooms. The additional cost of these rooms is typically between 1,000 - 5,000 yen per day, or $6.50 - $33.00. However, in some hospitals, it can be as much as 30,000 yen, or $200 per day.

**Cost Inflation and Cost Containment**

Contributions to the Government Health Insurance Plan have been very stable throughout the 1980s. In fact, they reached a peak in 1981 of 4.25 percent each for employer and employee. However, before March 1984, employees were not subject to the 10 percent co-payment. Prior to the 1980s, contributions had increased regularly over a 30-year period from 2 percent each in 1948.

Contributions are set broadly to cover costs and to finance a reserve fund. In 1987, for the first time in 15 years, medical expenditures exceeded income as a result of increased costs for elderly people. This has reduced reserve funds and fueled increased co-payment limits.

Premium rates for private insurance are set by tariff. The volume of insured health care is small, but limited data available indicate a significant increase in costs. Industry associations have also experienced higher expenditures than income and their contribution rates are likely to increase.

**The Future**

The level and extent of health care in Japan is comparable with the best in Western nations. Technology and the latest techniques are similarly up-to-date and widely available. There are no significant waiting lines for any form of treatment in Japan. Average lengths of stay in hospitals tend to be longer in Japan than in the U.S., Canada and the U.K. However, as Japan's
population continues to age, the demands for geriatric care are sure to increase. Long term care is pretty much left to the family to provide.

While medical costs are still far behind the U.S., they are increasing rapidly in Japan, and the Government is continuing to encourage private industry to take on a greater share of the burden.
APPENDIX TWO

SELECTED PRIVATE SECTOR MANAGED HEALTH CARE PROGRAMS

The private sector has been searching for years for better ways to control health care costs that had the support of employees and unions. Some of these pioneering programs are discussed in this section. They demonstrate that determined employers can make a difference in the cost and quality of their health care programs. As more is learned about the programs' effectiveness, their successes can be replicated or adapted by other companies, and public programs as well.
PART ONE

SOUTHWESTERN BELL CORPORATION'S
CUSTOMCARE: A MANAGED HEALTH CARE PLAN

Plan Development

Southwestern Bell Corporation's (SBC) health care costs increased 217 percent between 1979 and 1985. As a result, SBC began looking for ways to control spiraling costs without compromising the care offered its employees and retirees. The CustomCare concept was developed by SBC in conjunction with various insurance carriers. The managed health care plan was refined and agreed to during collective bargaining agreements between 1986 and 1989.

The CustomCare plan, unique at its introduction on April 1, 1987, has become a model for corporate health insurance plans. The reason is simple: it helps control rising health care costs without sacrificing quality of care.

CustomCare controls costs without automatically shifting costs to the plan participants. Instead, it gives participants choices and the opportunity to take a more active role in their health care. At the same time, the plan gives health care providers incentives to offer quality care. CustomCare was also designed to control postretirement benefit costs and promote wellness.

CustomCare blends the best features of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and indemnity plans. From HMOs come pre-certification, utilization review and an emphasis on wellness; from PPOs, negotiated provider discounts; and from indemnity plans, flexibility and freedom of choice.

How CustomCare Works

The insurance carrier administers the program and enters into agreements with doctors, hospitals, and other health care providers that meet its qualifications. Network providers foster the delivery of quality managed health care. Networks currently are set up in 13 major metropolitan areas where approximately 65 percent of SBC's employees and retirees live.

When an employee receives services at the direction of a participating primary care physician, he or she is charged a $10 co-payment for an office visit. After the co-payment, the plan basically provides 100 percent benefit for most items.
Employees using the CustomCare Network do not have to file medical claims. Network participants receive other benefits, such as home health care, hospice care and preventive care, such as well-child care.

Employees using the network have the flexibility to use a non-network provider on a service-by-service basis. However, since non-network services are more expensive to the company, employees who opt to use such a provider incur a front-end deductible ($350 per individual, $700 for two people, and $1,050 for three or more) and a 20 percent co-payment.

**CustomCare Performance**

From a financial perspective, CustomCare has been relatively successful. SBC has experienced continued growth in medical care expenses:

- From 1987 to 1988, the per person claim cost increase was 12 percent compared to the national average of 18-20 percent.

- The increase in per person CustomCare claims cost from 1988 to 1989 was less than 10 percent compared to the national average of 20 to 24 percent.

When surveyed, 82 percent of SBC employees using CustomCare think highly of care received and 36 percent thought care was better than received in the past.

A program evaluation was undertaken by SBC. The analysis focused on changes in utilization and cost patterns over a four year period -- 1985 to 1988. (CustomCare Networks were introduced at different times throughout 1987 and 1988 with the first Network operational July 1, 1987.)

Findings of the evaluation include:

- Before CustomCare (prior to April 1, 1987), increases in per capita costs averaged 14.8 percent per year. After CustomCare, increases averaged 2.4 percent per year.

- Actual costs were 3.1 percent below the trend line in 1987 and 12.1 percent below expected in 1988. On average, the total aggregate experience was 8.9 percent below expected following CustomCare introduction.

- An important factor affecting costs in the basic company medical plan was the migration of employees from the plan to HMOs during the year CustomCare was introduced (1987). But
for 1988, the trend began to reverse itself with 22 percent of the employees enrolled in HMOs (1987 HMO enrollment was 23%). Employees switching to HMOs in 1987 would have incurred an average expense of $1,673 had they remained in CustomCare. The actual cost of an employee in an HMO in 1987 averaged $1,996.

- From 1985 to 1988, SBC's per employee costs increased 47.5 percent. The largest increase was in the CustomCare transition year (1987) when expenses jumped 26.5 percent.

- The unadjusted rate of growth in per employee costs has been lower in Network cities when compared to Outside Network Areas. Compared to the 1985 base year, per employee paid amounts increased 44.1 percent in Network cities versus 53.6 percent in Outside Network Areas.

- Consistent with the trend throughout the United States, health care costs shifted from inpatient to outpatient care: 31 percent outpatient in 1985; 47 percent in 1988. At the same time, the cost of inpatient care increased sharply. The cost of a hospital day of care increased from $472 in 1985 to $758 in 1988.

**CustomCare's Future**

CustomCare has reduced SBC's health care cost trend. The Networks have been more effective than the Outside Network Areas in limiting the growth in costs. However, CustomCare is not a finished product. The plan will continue to evolve as it is monitored, studied and "fine tuned" in the years to come.
PART TWO

ALLIED-SIGNAL'S HEALTH CARE CONNECTION PLAN

On March 1, 1988, Allied-Signal implemented a managed health care plan for its salaried and non-union hourly employees and has just completed its second plan year. The plan, phased-in over a three-year period, requires corporate surveillance and involvement to make it work effectively. The company is no longer a passive payor of the health care bill for its employees and their dependents. Allied-Signal's Health Care Connection Plan now covers approximately 113,000 employees and their dependents in 26 health care networks across the country.

Allied Signal's health care costs are increasing at a lower rate than most U.S. employers -- thanks to the new managed health care approach and the financial arrangement that was negotiated.

In 1987, Allied Signal's health care costs for employees, dependents and retirees increased by 39%. Projections at that time indicated that if the company continued its health plans without change, costs would increase at a health care trend of 20% for each of the next three years.

For the period 1984 to 1986, the company's health care costs grew like most major companies at a reasonable level, at or below the medical CPI. Cost increases were controlled during this period by a series of plan changes and the introduction of various cost management techniques, such as hospital pre-admission certifications and second surgical opinion programs. Employees were also required to share more of the costs in the form of higher contributions and deductibles.

Most of the cost containment efforts of the early 1980s did not help control the amount and type of medical services and supplies being used. In 1987, management was convinced that action was needed to slow down the rate of health care cost increases, to find a more affordable way to provide quality care for active employees and dependents, and to restructure retiree medical plans. Management also recognized that health care costs must be managed like a business and that companies that take decisive action on health care costs will be ahead of the competition.

How Health Care Connection Works

The plan encourages, rather than forces, employees and their dependents to use the managed care network. Participants are able to choose whether to use a network physician or any doctor, each time they require care. This is called a "point-of-service" option.
If participants choose a network primary care physician, there is a $10.00 co-payment for an office visit and a $5.00 co-payment for prescription drugs. If they go outside the network to a non-network physician, they are reimbursed at 80 percent after meeting a deductible of 1 percent of pay for the employee and 3 percent for the family. As an inducement to use the network, preventive care services are provided. While employees have a financial incentive to seek care from a network physician, they have the freedom of choice to visit any doctor and pay more.

Allied-Signal contracted with a major insurer to design a program using 26 networks across the country where company employees live and work. By using the 26 networks, the company was able to gain access to qualified providers who had already passed the insurer’s credentialing requirements. The insurer’s networks are mostly IPA (individual practice associations); that is, the physicians practice in their own offices and treat fee-for-service patients as well as HMO participants.

The insurance company has assumed the role of the health care manager which includes accepting the risk; the insurer’s contract with Allied-Signal guarantees that the level of increases in the company’s health care costs would be kept at single digits each year for three years. If costs are below the guaranteed levels, the insurer keeps the surplus. The insurer is now the only carrier for the company’s salaried and non-union hourly employees and for most of the retirees.

In implementing the managed care program, most of the HMOs were eliminated because they were being paid more than they should have been for the risks they were assuming since contributions to the HMOs were based on the cost of the indemnity plans. By eliminating the HMOs, Allied-Signal was able to use this leverage to negotiate with companies interested in the managed care business.

**Health Care Connection Performance**

Nationally, about 75.4 percent of Allied-Signal employees and dependents are using the networks 95 to 100 percent of the time. The actual cost is running substantially lower than the trends in 1988 and 1989 for managed care programs. The overall per capita employee cost for the Health Care Connection on an annualized basis for the first eighteen months of the program is $2,450.00, compared to a projected $3,200.00--23 percent less than if the company had not changed from providing indemnity plan benefits. This represents a reduction in health care cost of approximately $750.00 per employee covered by the Health Care Connection. This comparison uses an indemnity trend of 18 percent, which is less than most carriers’ book of business trends, which ran approximately 20-26 percent for that period. Network usage continues to increase on a month-to-month basis. Hospital stays have averaged 4.8 days for program participants, compared
to 7.3 days for employees in the regular indemnity plan. Allied-Signal expects that the program will save the company $200 million over the program's three year course.

It was important that corporate management take the necessary action to fix problems as quickly as possible. Basically, the biggest challenge to making this kind of program work is the management challenge. Good employee communications are extremely important in implementing such a new health benefit program. Each company interested in managed care must decide what is the proper arrangement for them.
PART THREE

FIRST INTERSTATE'S HEALTH SPAN

Plan Development

In late 1987 and early 1988, First Interstate Bancorp experienced an alarming increase in medical plan costs. At that time, the bank offered a traditional comprehensive indemnity plan in over 20 states to 36,000 employees and 6,000 retirees. The plan provided traditional 80 percent coverage after a deductible was met. Several alternative HMO choices were also offered.

First Interstate's indemnity plan was rapidly losing money due to general resurgent health care inflation and plan utilization by participants. It was thus decided in mid-1987 to make moderate rate adjustments for January 1988, but later information indicated the new rates would be insufficient to avoid a multi-million dollar shortfall by the end of 1988. Between 1987-88, the bank experienced a 35 percent increase in costs.

First Interstate was very concerned about being able to provide affordable health care coverage to employees and retirees and, at the same time, allow them freedom of choice in making their health care decisions. Therefore, in early 1988 First Interstate implemented, as part of an overall corporate strategic plan, a new managed health care program.

How Health Span Operates

Throughout most of 1988, First Interstate worked closely with a major insurance company and benefits consulting firm on the design, administration, costing and communication of the new managed health care program.

Implementation of the managed health care program began in four states on January 1, 1989. This innovative program, covering 75 percent of the work force, would allow active employees and retirees under age 65 to choose the type of benefits they wish to receive at the time they need care. At "point-of-service," therefore, they would receive HMO-type benefits if they use doctors and hospitals within an established network of contracted providers. Not using the network would mean benefits would be paid at 70 percent of reasonable and customary covered charges, after an annual deductible — $250 per individual and $750 per family — is met.
The other 25 percent of the work force, and retirees age 65 and over, would be eligible for "no-network" coverage: 80 percent reimbursement after meeting an annual deductible similar to the old indemnity plan. Additional contributions to the medical plan would be made in the last half of 1988 to decrease the deficit.

The insurer was responsible for contracting with qualified physicians and hospitals in the four "network" states (Arizona, California, Colorado and Oregon).

First Interstate communicated the program to employees in a series of newsletters, payroll stuffers, posters and in annual enrollment materials. This was a demanding, vigorous process, involving several disciplines, including finance, legal, actuarial, benefits planning and communications teams.

In October and November of 1988, employees and retirees in the four network states enrolled for their 1989 health care coverage. People selecting the new managed care plan, called Health Span, were able to select personal care physicians for themselves and their covered dependents. Each dependent was able to select a different personal care physician. In addition, female participants were allowed to select an OB/GYN physician.

Personal care physicians are an integral part of the Health Span managed care program—they are charged with directing participants' day-to-day care, referring them to network specialists as necessary. As such, the personal care physician is the key to the highest benefits payable under the plan; employees not using their personal care physician receive much lower benefits.

In early 1989, First Interstate asked the insurer to do additional contracting in each network state so that more areas were well represented by hospitals and physicians. Throughout 1989, the network was expanded within the four states and ended the year with a very complete panel of providers. In 1990, five new states are to be added to the network either through direct contracting between the insurer and providers, or through contracting with existing networks.

The managed health care program meant making significant adjustments for many employees. Besides selecting a personal care physician (who in many cases was a new doctor for the person), employees had to be aware of contacting their personal care physician to receive the highest benefits under the plan. They could still go to their own specialist directly, but with lower plan benefits. There were many transitional, ongoing care issues that were addressed one by one with the insurer and affected employees and retirees.
Plan Performance

Claims experience for 1989 indicates that the Health Span program is helping to manage First Interstate's health care costs as evidenced by 1989's single-digit cost increases, compared to the two previous year's double-digit increases. First Interstate continues to be enthusiastic about Health Span's ability to deliver meaningful benefits at a reasonable cost to employees and retirees. Initial employee resistance to the plan has been largely overcome.

In 1991, further expansion of the network and monitoring the quality of care provided by the program will be explored.
PART FOUR
HEALTHLINE: UTILIZATION MANAGEMENT PROGRAMS IN FEE-FOR-SERVICE PLANS

Background

While some major companies have abandoned their traditional fee-for-service (FFS) plans for integrated managed care networks, other employers have sought to implement effective utilization management programs for their existing indemnity plans. For example, American Express, Coca-Cola, GenCorp, General Foods, RJR-Nabisco, and Sun Company have implemented managed care through Healthline, a family of utilization management programs developed by a major health insurer. * These employers have implemented one or more of the Healthline programs to assure that they are paying for efficiently provided, medically necessary health care services.

This program aims at assuring the highest quality medical care while reducing inappropriate care and employer’s costs. Additionally, these programs operate before medical care is rendered and help the individual avoid the inconvenience, discomfort and costs of unnecessary procedures.

Working with practicing physician-experts in various medical and dental specialties, standards were developed to guide determinations of appropriateness. A procedure is appropriate for an individual if the medical experts in that procedure believe that the benefits outweigh the risks. Independent researchers affiliated with the Rand Corporation and Harvard Medical School were consulted and, together with the practicing physician-experts, medical guidelines or “protocols,” were developed that define what appropriate care is for most individuals.

* This is only one of many programs on the market today with somewhat similar components.

Inpatient Care

Prior to a planned hospital admission, an employee calls a Healthline nurse and the nurse in turn interviews the employee’s doctor. The nurse, using medical criteria which define the most efficient and effective method of delivering medical care, asks specific questions about the patient’s symptoms, clinical findings and test results. With the help of a computer, the answers are tabulated and compared with expert opinion. About 10 percent of the time, the nurse refers the case to a physician advisor who discusses the case further with the employee’s doctor.
The intent of this program is to reduce inappropriate use of inpatient facilities. This program has been shown, to generate a net savings of 8 percent of inpatient costs. (Data in this section are from Healthline.) This research has been validated by independent health economists.

These programs work most effectively when there is an incentive for the employee to notify the nurse before the hospital admission. Failing to call leads to increased out-of-pocket health care expenses for the employee.

**On-Site Nurse Management**

One of the most effective ways to influence physicians toward more efficient and effective care is to place a utilization management nurse in the hospital. Over time, the nurse becomes familiar with individual physician's practice patterns and, using clinical criteria developed by experts, is able to influence physicians toward a higher standard of medical care. On a daily basis, the onsite nurse reviews the inpatient medical record and visits with the patient. Comparing what has been proposed in the treatment plan to criteria developed by experts, the nurse is able to assess whether the proposed treatment is medically necessary or not.

Analysis of this program reveals that when combined with the inpatient program described above, a net health care cost savings of 9 percent, in addition to savings from prior review of inpatient care.

**Managed Mental Health**

In 1989 it was not unusual for an employer to spend 15 - 20 percent of health care dollars on psychiatric and substance abuse treatments. These costs have soared in the last several years; 1989 saw increases of 47 percent. Employers have been anxious to manage this area of health care more effectively.

A program called Managed Mental Health has succeeded in significantly reducing overutilization of these services. This program combines an employee assistance program (EAP) and a psychiatric/substance abuse program with a preferred provider organization. Typically, health plans featuring managed mental health care contain financial incentives for the patient to be counseled in the EAP and not self-refer to a provider. EAP counselors typically counsel the employee during four to six sessions, and if necessary, refer the patient to a preferred provider. The counselor continues to manage a case after referral.
Seventy percent of the time the counselor is able to treat the patient successfully. Fifteen percent of the time the counselor is able to refer the patient to no-cost community resources, and the remaining 15 percent of the time the counselor refers the patient to a preferred provider.

Pilot tested in 1987 and recently statistically studied for several large employers, Managed Mental Health has been shown to yield a net savings in psychiatric and substance abuse costs of 20 percent.

**Outpatient Procedures**

Outpatient utilization and costs for all payors have risen dramatically over the past five to six years as physicians became more comfortable performing procedures on an outpatient basis, new technology increased rapidly, and volume controls on these services were lacking. Working with physician researchers affiliated with the Rand Corporation and physician experts in various outpatient procedures across the country, criteria were developed in 1987 for determining whether proposed outpatient procedures are medically necessary.

A series of protocols were developed for certain overutilized outpatient procedures. Each protocol, with reasonably high accuracy, determines when a procedure for a given patient should or should not be done. The protocols duplicate the thought processes that a physician goes through before recommending that a procedure be performed. By interviewing the patient’s doctor and asking specific questions about the patient’s symptoms, physical findings, test results and what alternative treatments have been tried, it is possible to determine with a reasonable level of accuracy whether the procedure is being suggested for appropriate reasons. The interview takes no more than four to five minutes of the doctor’s time and has not been found to be objectionable to most physicians.

While it is too early to tell if this program is effective in reducing inappropriate outpatient utilization, preliminary information suggests that it is effective.

**Inpatient Surgery**

There is now ample evidence in the medical literature that certain inpatient surgeries are frequently performed for inappropriate reasons. Using a methodology similar to the outpatient protocol-based system, a set of protocols were developed in 1988 to control the inappropriate utilization of certain inpatient procedures. This time, working with a group of clinicians affiliated with Harvard Medical School, a series of protocols were developed. Again, these protocols, with reasonable accuracy, are able to determine whether the inpatient surgery is being suggested by
the patient's doctor for appropriate reasons. It is through this clinical discussion about a specific patient that the doctor is influenced to practice more effectively and efficiently.

Since the program has only been in effect for several months, it is too early to confirm its effectiveness in controlling inpatient surgeries.

Conclusion

Advances in research on medical appropriateness have significantly increased effective options for containing medical and dental care costs in traditional fee-for-service plans. Through the use of criteria and protocols developed by outside physician experts, the appropriateness of medical care being suggested for patients can be evaluated and discussed with the patient's doctor. Each of the programs that has been in place long enough to be adequately analyzed will generate a net savings of approximately 7-10 percent of health care costs for the employer.

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