

American Exceptionalism in the Health Sector: The Advantages of “Backwardness” in Learning from Abroad

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The United States is the only industrially advanced nation with over 15 percent of its population uninsured for health care services.¹ This aspect of American health policy has earned us a reputation of “backwardness”; for both Western Europe and Canada have systems of universal entitlement to health care.

Should we adopt the Western European or Canadian models of health care financing and organization? Or should we maintain our present system and recognize that it is a manifestation of American exceptionalism, i.e., of the ways in which the United States is fundamentally different from Western Europe and Canada? Comparative analysts often emphasize the possibilities of adopting elements of health care systems from abroad. But there is also a deeply rooted skeptical variant to this school of thought: those who emphasize the importance of American exceptionalism and who presume that comparative studies of health systems are not useful for policy learning.²

Both of these responses are probably inappropriate. The second re-

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sponse—that comparative analysis is not useful—insulates us from the experience of other nations. It is ethnocentric; it tends to make us conservative; and, therefore, it supports the status quo in the United States. The first response—that we should adopt the Western European or Canadian models—relies too heavily on the experience of these nations. It is misleading because there are serious limitations in the Western European and Canadian health systems. Moreover, the United States is less backward than it appears. Many of the present institutional arrangements of health care delivery are superior to those abroad.

Thorstein Veblen has pointed out the basic advantages of “backwardness” in learning from abroad: the mistakes of those who are “ahead” need not be repeated.³ Drawing on Veblen’s idea, I propose a third response to the question of whether we should adopt Western European or Canadian models of health care financing and organization, or maintain our present system. I suggest that it would be appropriate to ask how the best features of each system might be combined.

Instead of studying health systems abroad to learn how we can adopt certain of their characteristics in the United States, I will focus on three proposals for health sector reform in France, Canada and Britain. Each proposal introduces an innovative American idea—Health Maintenance Organizations (HMOs)—into national systems that provide universal entitlement to health care. This represents a new approach for comparative studies of health policy. It recognizes the nature of American exceptionalism in the health sector. Also, it highlights common problems of health care financing and organization in Western Europe, Canada and the United States. Finally, it provides an opportunity to examine convergent solutions to these problems from the point of view of American health policy concerns.

AMERICAN EXCEPTIONALISM: IMAGES AND REALITIES

Tocqueville observed that the “great advantage” of the American lay in that he did not have to “endure a democratic revolution”.⁴ That insight into American life is one of the earlier and more well known attempts to explain why the United States is different from Europe. Why, in the United States, did there not develop either a mass socialist movement, or the kinds of social democracies that still prevail in Western Europe or Canada?⁵

In comparison to Canada and Western Europe, the United States is commonly regarded as a “welfare laggard” (Wilensky 1975); or, at best, as a “reluctant welfare state” (Bendick 1985). In this respect, the case for

American exceptionalism is most often based on two contentions. First, the United States was no pathbreaker in the adoption of major social programs. Social security, workmen's compensation, unemployment insurance and public housing were generally adopted later in the United States than in Western Europe and Canada. Second, the scale of public expenditure on social programs in the United States was generally smaller than in Western Europe and Canada.

Both of these contentions hold in the health sector. Indeed, two distinguishing characteristics of the American health system are the absence of a compulsory and universal national health insurance (NHI) program and the relatively low level of public expenditure on health care. Although the component elements of an NHI system already exist in the United States (Medicare for the elderly and handicapped and Medicaid for the very poor), these programs were adopted later than in Western Europe and Canada. What is more, long before these programs were adopted, the United States opted in the 1930s for a system of private health insurance. Although this was not the outcome of explicit health policy decisions, a number of federal policies outside of the health sector, e.g., the exemption of fringe benefits from wage controls during World War II and their largely 'tax-exempt status since then, provided indirect subsidies to the private health insurance industry (Starr 1982). As a result, beginning in the 1930s this industry grew and remains an important source of health care financing.

In summary, there is some evidence for American exceptionalism in the health sector. But there are also important ways in which the health sector in the United States resembles that of Western Europe and Canada. Let us examine this issue from the vantage point of three characteristics that typically distinguish the United States from Western Europe and Canada: (1) American values and popular opinion; (2) the structure of health care financing and organization; and (3) policy responses to health sector problems.

AMERICAN VALUES AND POPULAR OPINION

The prevailing image of American values and popular opinion is that of nineteenth-century liberalism—what Hartz (1955) calls the "irrational liberal faith of America". Liberalism has colored American perceptions of equity, of the proper role for government, and of citizenship. These perceptions represent a range of American values and popular opinions which distinguishes the United States from Western Europe and Canada.

American attitudes about equity with regard to health care were formed in the nineteenth century as large numbers of immigrants settled in the country's urban centers. During this period, the concept of the "truly needy" emerged (Rosner 1982). Many Americans developed a sense of responsibility to come to their aid, but there were also harsher attitudes inspired by social Darwinist notions which distinguished between the "truly needy" and the "undeserving" or "unworthy" poor. Whereas in Western Europe powerful interest groups (including the socialists) viewed poverty as an outcome of the economic system, the predominant inclination in the United States was to regard poverty as an individual problem. Hence, greater attention was focused on *equality of opportunity* in the United States, compared with *equality of result* in the more left-leaning European social democracies.

As far as the proper role of government is concerned, the United States has a long history of antigovernment attitudes in contrast to Western Europe and Canada. The suspicion about excessive governmental authority and the attachment to individual liberties is a pervasive American value (King 1973).

American perceptions of citizenship also present a striking contrast to Western European perceptions. Since the early days of the republic, a limited number of social groups in the United States were identified as needing or deserving special direct medical care or payment for services. First, for example, the merchant seamen; next, veterans; the blind; and so forth. This pattern of successively enlarging entitlements was also pursued in Europe and Canada. In the United States, individualist values, on the one hand, and social and ethnic heterogeneity, on the other, have resulted in what Klass (1985) calls "fractionalized understandings of citizenship". In Western Europe, the understandings of citizenship are grounded in notions of solidarity and universal entitlements. The difference is that Europe and Canada have largely succeeded in covering all their citizens under some form of health insurance; the United States has not.

There is a general aversion among Americans to universal entitlements. As Uwe Reinhardt (1985) observes, when Americans face a trade-off between establishing tax-financed entitlements and leaving the uninsured on their own, they prefer to do the latter. It would be misleading, however, to draw any conclusions about how generous Americans are or how much social welfare they provide based only on the image of liberalism outlined above.

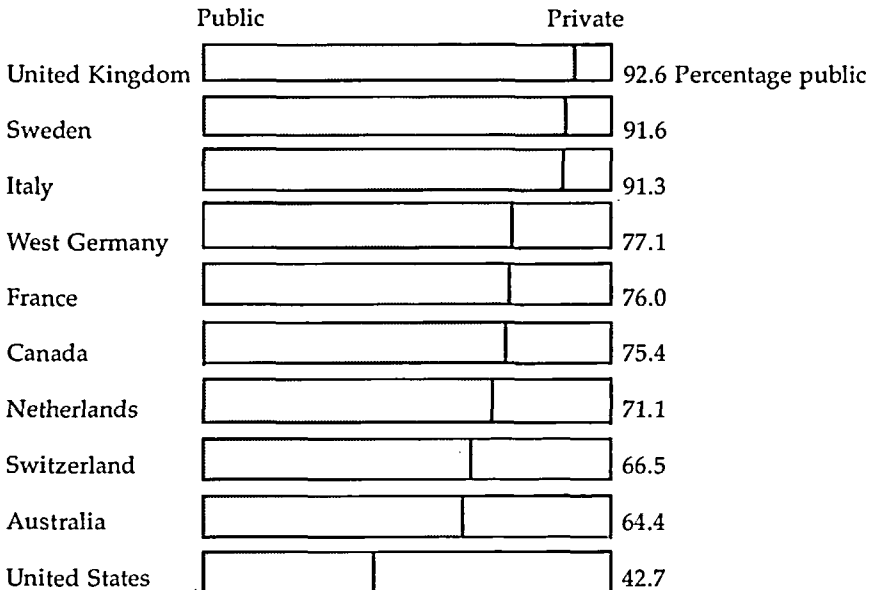
As we will see in the next section, the United States spends more on health care than any other industrially advanced nation. Based on an analysis of cross-national differences in kidney dialysis rates, Prottas,

Segal and Sapolsky (1983) suggest that American "compassion" is the cause for the disproportionately large number of dialysis services available in the United States.⁶ In contrast to Western Europe and Canada, Americans prefer to promote redistribution policies through local assistance, charities and indirect subsidies to the voluntary sector via tax exemptions. These preferences led Klass (1985) to suggest that American social policy represents a form of "decentralized social altruism" in which significant collective action occurs at the community level. Clearly, there are important elements of American exceptionalism with regard to values and popular opinion. But how much of a difference do these differences make?

THE STRUCTURE OF HEALTH CARE FINANCING AND ORGANIZATION

The prevailing image of the American health system is one of a privately financed, privately organized system with multiple payers. These characteristics derive, in large part, from the absence of a publicly man-

FIGURE 1 Sources of Finance for Health Care Expenditures: The Mix between Public and Private in 1975 as a Percentage of Total



Source: Robert J. Maxwell, *Health and Wealth* (Lexington, Mass.: Lexington Books, D. C. Heath and Co., 1981). Reprinted by permission of the publisher.

dated NHI program. And they are the essence of American exceptionalism in health care financing and organization. But after examining the evidence, one wonders whether the differences between the United States and Western Europe and Canada are differences of form or substance.

In comparison with ten Western European nations and Canada, the United States is last with respect to the public share of total health expenditures (Figure 1). Although the United States is the highest health care spender (public and private combined) as a percentage of gross domestic product (GDP), it still retains the lowest share of public expenditure as a percentage of GDP (Table 1). The same pattern is observed in comparing public health expenditures for the elderly as a percentage of GNP (Table 2).

TABLE 1 Health Care Expenditures, 1982

	<u>% Public Expenditures on Health in GDP</u>	<u>% Total Expenditures on Health in GDP^a</u>
Australia	4.8	7.6
Austria	4.7	7.3
Belgium	5.8	6.2
Canada	6.1	8.2
Denmark	5.9	6.8
Finland	5.2	6.6
France	6.6	9.3
Germany	6.6	8.2
Ireland	7.7	8.2
Iceland	6.6	7.6
Italy	6.1	7.2
Japan	4.8	6.6
Luxembourg	7.4	6.5
Netherlands	6.9	8.7
New Zealand	5.1	5.7
Norway	6.6	6.8
Sweden	8.9	9.7
Switzerland	4.7	7.8
United Kingdom	5.2	5.9
United States	<u>4.5</u>	<u>10.6</u>
OECD Average	5.8	7.4

Source: *Measuring Health Care, 1960-1983* (Paris: OECD, 1985). Based on data in Table 2, p. 12.

^aPreliminary estimates for 1984 may be found in G. J. Schieber and J. P. Poullier, "International Health Care Spending," *Health Affairs* 5 (Fall 1986): 111-22.

TABLE 2 Public Expenditures for Health Care of the Elderly, 1980

	<i>Public Expenditures as Percentage of GNP^a</i>
United States	3.9
Canada	5.8
Denmark	6.4
France	6.1
Germany	6.2
Netherlands	6.5
Norway	5.8
Sweden	8.9
Switzerland	4.5
United Kingdom	5.2

Source: Adapted from U.S. Senate, Special Committee on Aging, *Long-Term Care in Western Europe and Canada: Implications for the United States* (Washington, D.C.: Government Printing Office, July 1984).

^aOrganization for Economic Cooperation and Development, "Expenditures on Health Services," draft (Paris: OECD, April 1983); and International Monetary Fund, *International Financial Statistics Yearbook* (Washington, D.C.: The Fund).

The organization of health care in the United States is noted for being on the private end of the public-private spectrum. In comparison with Western Europe, the United States has one of the smallest public hospital sectors. In the organization of ambulatory care, American private fee-for-service practice corresponds to the norm, at least in comparison to NHI systems. However, the absence of an NHI program in the United States has resulted in a system of multiple payers and has encouraged a more pluralistic pattern of medical care organization and more innovative forms of medical practice: e.g., multispecialty group practices, ambulatory surgery centers, Preferred Provider Organizations (PPOs) and HMOs.

Likewise, evidence of American exceptionalism appears in the ways in which health resources are used. For example, the United States has fewer hospital beds per thousand population than any Western European country or Canada. It also has the lowest use of inpatient care (Table 3). These data should not necessarily lead one to the conclusion that the United States is less prone to institutionalize patients than Western Europe or Canada. They probably reflect the fact that elderly patients in the United States who require long-term care are more quickly discharged to the nursing home industry, which has no equivalent in Western Europe or Canada.

TABLE 3 Hospital Beds and Use of Inpatient Care, 1982

	<i>Number of Beds per 1000 Persons</i>	<i>Hospital Bed-Days per 1000 Persons per Year</i>
Australia	6.8	3200.00 ^a
Austria	10.7	3400.00
Belgium	9.4	2800.00 ^a
Canada	6.8	2100.00
Denmark	7.7	2200.00
Finland	15.6	4800.00
France	11.1	3100.00
Germany	11.1	3400.00
Iceland	10.6	3900.00 ^a
Italy	7.9	2200.00
Japan	11.9	3600.00
Luxembourg	13.1	3800.00
Netherlands	12.0	4000.00
Norway	6.8	2000.00 ^a
New Zealand	10.0	2700.00
Sweden	14.0	4800.00 ^a
Switzerland	11.5	3100.00
United Kingdom	8.0	2400.00 ^a
United States	5.9 ^b	1700.00 ^a

Source: *Measuring Health Care, 1960-1983* (Paris: OECD, 1985). Based on information from Tables D.1, D.4 and H.1.

^a1981 data.

^bThis figure includes beds for all hospitals registered with the American Hospital Association.

These are ways in which health care financing and organization in the United States differ from Western Europe and Canada. But there are also some noteworthy points of similarity. For example, most health systems in industrially advanced nations are centered around the hospital. They allocate roughly one-half of total health care expenditures to the hospital sector. The United States corresponds to the norm in this regard (Table 4). Outside the hospital, once again, the United States is close to the mean in expenditures on specialist and primary care as a percentage of total health care expenditures (Figure 2).

There is also a high degree of similarity between the United States, Canada and Western Europe in the broad structure of health care financing and provider reimbursement. The essential feature of modern health care systems is the central role of third-party payment. What matters to the consumer with regard to health care financing is not the relative public

TABLE 4 Components of Health Spending, 1981 (percent of total health spending)

	<i>Spending as Percentage of Total</i>			
	<i>Institutional</i>	<i>Ambulatory</i>	<i>Pharmaceutical</i>	<i>Other</i>
Australia	54.0	16.7	8.0	21.3
Belgium ^a	35.8	41.6	17.0	5.6
Canada ^b	55.1	21.8	9.4	13.7
Finland ^a	48.8	29.7	10.4	11.1
France ^a	46.2	26.0	15.7	12.1
Germany ^b	38.6	26.7	20.2	14.5
Ireland ^{p b}	71.8	11.5	7.0	9.7
Italy ^a	50.9	31.9	15.9	1.3
Luxembourg ^{p b}	32.5	21.5	12.0	34.0
Netherlands ^a	58.8	26.4	9.8	5.0
New Zealand ^{p c}	69.2	7.1	11.5	12.3
Norway ^p	69.9	15.3	7.2	7.6
Sweden ^{p a}	72.6	10.2	4.9	12.3
United Kingdom ^{p d}	58.5	10.0	9.9	21.6
United States ^a	47.5	27.8	6.7	16.0
Mean ^e	54.0	21.6	11.0	13.2

Sources: G. J. Schieber, "The Financing and Delivery of Health Care in OECD Countries: Past, Present and Future" (Tokyo: Joint Japanese/OECD Conference on Health and Pension Policies in the Context of Demographic Evolution and Economic Constraint, November 25–28, 1985). The data in the table are from *Measuring Health Care, 1960–1983* (Paris: OECD, 1985).

^a1983.

^b1982.

^c1980.

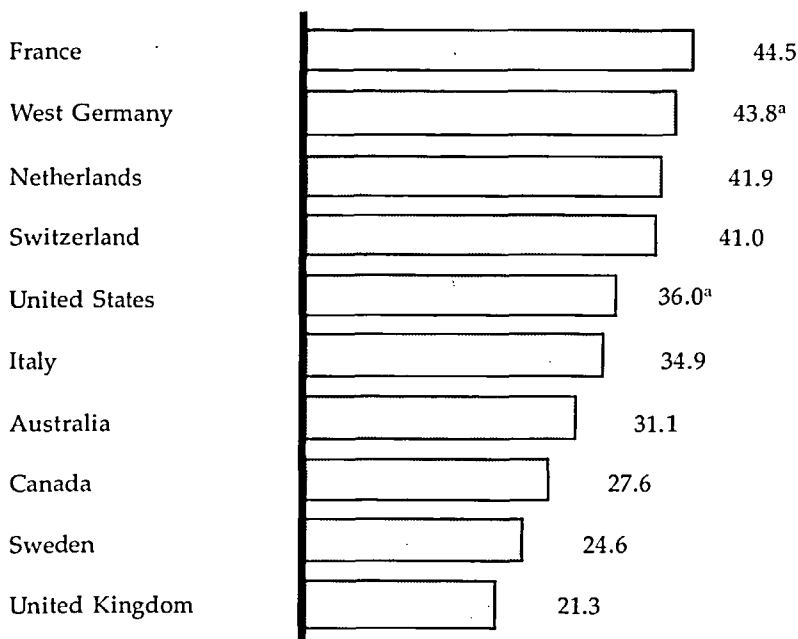
^d1979.

^eExcludes Austria.

^pPublic spending by type of service as a percentage of total public spending on health.

and private mix, but rather the relative portion of *direct* out-of-pocket payment versus *indirect* third-party payment (Rodwin 1987b). To emphasize the large private portion of health care financing in the United States is misleading; the more critical factor is that public and private health insurance are both forms of third-party payment. This amounted to 71.6 percent of national health expenditures in 1985 (Anderson 1986). To be sure, this leaves consumers with an out-of-pocket contribution equal to 28.4 percent of total health expenditures. By this indicator, once again, the United States is exceptional (Figure 3). But even under French NHI, consumers contribute roughly 20 percent toward total health expendi-

FIGURE 2 Expenditures on Specialist and Primary Care Outside Hospitals as a Percentage of Total Health Care Expenditures, 1975



Source: Robert J. Maxwell, *Health and Wealth* (Lexington, Mass.: Lexington Books, D. C. Heath and Co., 1981). Reprinted by permission of the publisher.

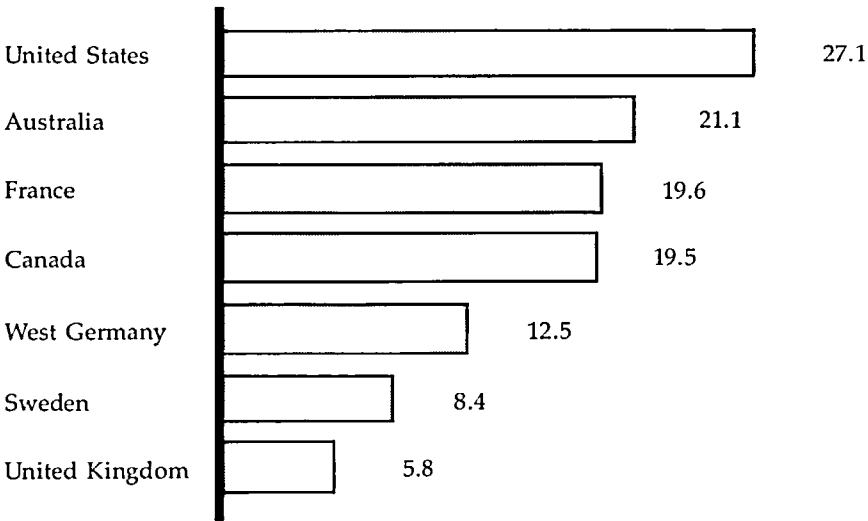
^aThe figure for West Germany includes expenditures on false teeth, rehabilitation services, and spa treatment from "other services". The figure for the United States was obtained by estimating for self-medication.

tures. The difference is not as large as our initial comparisons would have had us believe.

The image of a private organizational structure in American health care is well founded. But that view, too, is incomplete. In spite of its *relatively* small size, there is an important role for the public sector in the United States, both in ambulatory services for the noninstitutionalized patient and in the provision of hospital services.

With regard to ambulatory care, there are a maze of special federal programs and a network of local government services largely for the poor. The services are provided either in county or municipal hospital emergency rooms, in local health departments, or in neighborhood health centers. As for hospitals, more than 30 percent of all acute care institu-

FIGURE 3 Direct Payment for Consumers in 1975, Excluding Voluntary Insurance, as a Percentage of Total Health Care Expenditures



Source: Robert J. Maxwell, *Health and Wealth* (Lexington, Mass.: Lexington Books, D. C. Heath and Co., 1981). Reprinted by permission of the publisher.

Note: Information was not available for Italy, the Netherlands, and Switzerland.

tions are owned and operated by governments. This includes the federal Veterans Administration hospitals, marine and military hospitals as well as state and county hospitals. Although the "Great Society" programs, Medicare and Medicaid, were intended to bring the poor into "mainstream medicine", i.e., the private sector, local county and municipal hospitals continue largely to serve the poor. These hospitals are a major source of care not only for Medicaid beneficiaries but also for over half of the poverty population who do not meet Medicaid eligibility levels and, consequently, often do not have access to private physicians or voluntary hospitals.

To sum up, there are distinctive characteristics of health care financing and organization in the United States, but there are also striking points of similarity when compared with Western Europe and Canada. American exceptionalism is characterized by the absence of an NHI program; by preferences for institutional flexibility; and by innovative forms of medical care organization. The points of similarity—the coexistence of both public and private provision and third-party payment—are structural characteristics of the American health system, as well as of most other health systems.

POLICY RESPONSES TO HEALTH SECTOR PROBLEMS

Are policy responses to health sector problems in the United States also exceptional? In a recent paper, Brian Abel-Smith (1985) suggests that the United States is the “odd man out”. He argues that there is a growing divergence between Western European and American policy responses to the problem of containing health care costs. Western Europe continues to rely on regulation, which Abel-Smith contends is not merely effective but “can take a whole variety of ingenious and innovative forms”. In the United States, by contrast, Abel-Smith notes that regulation has gone out of fashion and has been replaced by policies that promote competition and greater reliance on market forces. Examples of these unique American policy responses to health sector problems include: (1) the growth of deductibles, copayments and other cost-sharing mechanisms—what Abel-Smith calls “de-insurance”; (2) the trend toward making those who benefit from insurance actually pay the whole cost. This implies, for example, that reducing tax deductions will provide incentives for both employers and employees to shop more prudently for insurance coverage; and (3) the growth of competitive bidding as a mechanism of forcing competition between alternative providers.

There is some astute observation behind Abel-Smith’s caricature of the American policy response to health sector problems. But, Abel-Smith sometimes confounds rhetoric for actual practice. There is probably more regulation in the eastern states with “all-payer systems”, e.g., New York, New Jersey and Maryland, than in Western Europe. Even in well-known “pockets of competition”, e.g., California, Arizona and Minnesota, regulation is essential, if only to enforce the rules of the competitive game. The new Prospective Payment System (PPS) for Medicare provides a good illustration. Although one of its effects has been to intensify competition between hospitals, the use of DRGs for hospital reimbursement is actually

a highly regulatory strategy of centralized price controls (Luft 1985), one which falls well within Western European policy traditions.

In regulating physician activities, American policy has not backed off, as Abel-Smith suggests in assessing the experience of Professional Standards Review Organizations (PSROs). Rather, since the creation of Peer Review Organizations (PROs) under PPS, the regulation of physician behavior in the United States is surely stronger than any emerging European equivalent, including the French and Canadian systems of medical profiles which are among the most well developed outside of the United States.

Three characteristics distinguish American policy responses from those of Western Europe and Canada:

1. The United States has long been concerned about the dangers of monopoly power and has pursued (until the recent wave of mergers both inside and outside the health sector) a strong antitrust policy. As a result, it has promoted in the health sector what Lowi (1969) calls "interest group liberalism"—the push and pull of organized interest groups. A notable case in point is the recent action by the Federal Trade Commission to curb the monopoly power of physicians and hospitals, and to eliminate restraints on trade in health care by allowing advertising.⁷ Even if Alford (1975) is correct in arguing that interest groups in the health sector pale in comparison to what he calls "structural interests" (coalitions of groups), structural interests in the United States are neither formally sanctioned nor accepted as institutionalized counterparts for purposes of negotiating with the government (Stone 1980). Instead, the more typical response of American policy is to advocate proposals to fragment powerful groups that are presumed, as a consequence, to compete with one another.⁸

2. Following directly from the first characteristic of the American policy response is the absence of institutional structures in the United States for negotiating between major groups of health care providers and the government or an NHI board of directors, or both. In contrast to the more adversarial American approach which attempts to fragment both the medical profession and hospital associations, a strategy of "divide and conquer", the Western European and Canadian policy response consolidates the organization of provider groups and confronts them with countervailing organizations, a strategy of what might be called accommodationist corporatism.

In the United States, this important difference acts as a severe constraint on the possibilities of negotiating either a national fee schedule for physicians, or a uniform hospital payment system for *all* payers and hospitals. The constraint, however, has made it possible for individual payers, e.g., Medicare, Medicaid and private insurance companies, to limit

physician payment and to foster competition and new organizational arrangements for medical care.

3. The third feature of the American policy response to health sector problems may be characterized as a strategy of decentralized federal intervention (Rodwin 1984). In contrast to Western European and Canadian strategies of comprehensive health care reform and strong centralized regulation, with the exception of PPS for Medicare, American strategies are characterized by far greater decentralization and by more persistent social experimentation. Although major policy initiatives have usually come from the federal level, there is much discretion at the state level, and a range of government programs at the county and municipal levels. When compared to unitary European states such as France, American federalism provides a striking contrast. But even in comparison to other federal states such as Canada and Germany, the United States is still characterized by more decentralization and experimentation in the policy-making process. To cite only one example, the range of variation between state-run Medicaid programs in the United States is far greater than the variation between provincial health policies in Canada or sickness fund policies between the *lander* in Germany.

These three characteristics of American policy responses to health sector problems evoke the image of American exceptionalism. But the image fades a little when one examines the evolution of American health policy over the past four decades and the similarities of policy response between the United States, Western Europe and Canada.

Lawrence Brown (1985) classifies American policy responses into four categories: (1) the subsidy strategy—government grants on the supply side; (2) the financing strategy—third-party financing on the demand side; (3) the reorganization strategy—government inducements to promote new organizations for delivering medical care; and (4) the regulatory strategy—government attempts to influence the “use, price and quality of services, and the size, location and equipment of facilities”. Three of the four strategies—subsidy, financing and regulatory—describe equally well the Western European and Canadian policy responses to their health sector problems.

During the expansion phase of health care systems in the 1950s and 1960s, there was extraordinary convergence between Western industrialized nations around both the subsidy and the financing strategies (de Kervasdoué, Kimberly, and Rodwin 1984). In the mid-1970s and the 1980s, during the containment phase, there was also convergence around the regulatory strategy. As for the reorganization strategy, policymakers have tried to promote institutional change in all Western industrialized na-

tions. Indeed, if one were to summarize the generalized policy response to health sector problems in two words, they would be: chronic adaptation.

The proliferation of medical technology and an aging demographic structure are trends common to all modern health care systems. Policy-makers have been forced to respond. Although one can point to examples of the reorganization strategy in all countries, Canada, particularly Quebec, and Western Europe have focused more on administrative reorganizations in the public sector, whereas the United States has encouraged reorganization in the private sector at the level of the delivery system. With regard to the question of exceptionalism, this is perhaps the most notable aspect of the American policy response to health sector problems.

LEARNING FROM ABROAD

Given the ways in which the health sector in the United States resembles that of Western Europe and Canada and the ways in which it is exceptional, what inferences can one draw about the usefulness of comparative analysis for purposes of learning from abroad? If the United States is truly exceptional in the health sector, then one can argue that there is little to learn from Western Europe and Canada. Nations throughout the world rely on this "assumption of uniqueness" to reject ideas from abroad (Stone 1981). But since the United States is unexceptional in many respects, there is a case for learning from comparative experience. The problem, however, is *how* to do so. Unfortunately, the professional literature on this topic is of limited assistance.

IDEAS FROM THE LITERATURE

Comparative analysts of health systems have produced a large literature that provides profiles of health care systems abroad.⁹ There is even a two-volume bibliographic manual with appropriate taxonomies and summaries of relevant research (Elling 1980). But comparative studies of health policy are sparse. Most often, they describe national experience in a range of policy areas; only rarely do they interpret, let alone evaluate this experience. Exceptions to this general rule are of interest, because they have contributed at least three ideas that have implications for learning from abroad.

First, is the idea of evolutionary progress in health systems. Medical sociologists such as Field (1973) and Mechanic (1976) argue that health systems in Western industrialized nations are evolving in similar directions. Drawing on Field's typology consisting of five systems—the private health system, the pluralistic one, the NHI system, the national health

TABLE 5 The Evolution of Health Systems

<i>Health System</i>	<i>Type 1 Private</i>	<i>Type 2 Pluralistic</i>	<i>Type 3 National Health Insurance</i>	<i>Type 4 National Health Service</i>	<i>Type 5 Socialized Health Service</i>
General definition	Health care as item of personal consumption	Health care as predominantly a consumer good or service	Health care as an insured guaranteed consumer good or service	Health care as a state-supported consumer good or service	Health care as a state-provided public service
Position of the physician	Solo entrepreneur	Solo entrepreneur and member of variety of groups, organizations	Solo entrepreneur and member of medical organizations	Solo entrepreneur and member of medical organizations	State employee and member of medical organizations
Role of professional associations	Powerful	Very strong	Strong	Fairly strong	Weak or nonexistent
Ownership of facilities	Private	Private and public	Private and public	Mostly public	Entirely public
Economic transfers	Direct	Direct and indirect	Mostly indirect	Indirect	Entirely indirect
Prototypes	U.S.; Western Europe; Russia in 19th century	U.S. in 20th century	Sweden; France; Canada; Japan in 20th century	Great Britain in 20th century	Soviet Union in 20th century

Sources: V. G. Rodwin, *The Health Planning Predicament: France, Quebec, England, and the United States*, p. 245. (Berkeley: University of California Press, 1984). Adapted from : M. G. Field, *Comparative Health Systems: Differentiation and Convergence*, Final Report under Grant No. HS-00272 (Rockville, Md.: National Center for Health Services Research, 1978).

service (NHS) and the socialized health service—one might infer that the direction of change in modern societies is from the system of Type 1 to that of Type 5 (Field 1978). (See Table 5.) Unlike Field who would not interpret this direction of change as a sign of “progress”, Roemer (1977) describes similar trends as a march toward a health ideal.

The second idea, the notion of public policy learning is methodological in nature. It is highlighted in Glaser’s work and recent article (1984), “Juggling Multiple Payers: American Problems and Foreign Solutions.” Glaser has produced three major studies of health policy in Western Europe and Canada: (1) *Paying the Doctor* (1970) analyzes systems of physician remuneration; (2) *Health Insurance Bargaining* (1978) explains how alternative administrative arrangements affect the process of bargaining between the medical profession and the state; and (3) *Paying the Hospital* (1982) describes systems of hospital reimbursement and assesses the implications for the United States.¹⁰ Each of these studies starts with the presumption that the United States has many problems and that the policies and experience of Western Europe and Canada shed light on these problems and suggest useful solutions.

The third idea focuses on understanding either the determinants of health policies or at least their effects. Leichter (1979), for example, analyzes the determinants of health policies in Britain, Germany, Japan and the Soviet Union. Similarly, Altenstetter (1974) and Stone (1980) show how different structures and processes explain differences in policy between the United States and West Germany; Hollingsworth (1986) attempts to relate differences in structure and performance by comparing the United States and Britain. This approach views “most similar systems” as laboratories in which to assess the effects of alternative policy options at home (Teune 1978; Marmor, Bridges, and Hoffman 1978). It is exemplified by Evans (1984) and Marmor and his colleagues (1978) who used this approach in their studies of Canada. Aaron and Schwartz (1984) adopt such an approach in their study on the rationing of a variety of medical procedures in England and the United States. But as Marmor and Klein (1986) have noted, these nations may be too dissimilar for purposes of drawing valid policy implications.

The idea of evolutionary progress in the development of health systems suggests that the United States can learn by studying nations whose systems are more advanced. Similarly, the idea that policy learning brings foreign solutions to bear on American problems is a variation on this theme. Finally, the idea of using comparative analysis to understand the determinants and effects of policies abroad can assist us in evaluating alternative policy options at home. In this sense, we may avoid what Evans (1985) calls “the illusion of necessity over the reality of choice”.

AN ALTERNATIVE APPROACH: COMMON PROBLEMS AND CONVERGENT SOLUTIONS

The ideas cited above and, in general, the comparative health policy literature often overlook or minimize the substantial problems of health systems abroad. An alternative approach might be to reverse this emphasis. For example, in his historical study of health policies in Britain and the United States, Fox's (1986) concept of "hierarchical regionalism" may be interpreted as a convergent solution to common problems. His argument would probably apply to the rest of Western Europe and Canada, as well. Indeed, another way to think about learning from abroad is to begin with the recognition that most countries, irrespective of their particular health system, face common problems with regard to the efficient and equitable allocation of scarce health care resources.¹¹ A number of propositions may be adduced to illustrate this approach:

1. A major challenge in health policy for Western Europe, Canada and the United States lies in achieving control over the health sector, i.e., in linking policy goals to implementation (Rodwin 1984).
2. Although national health insurance (NHI) has succeeded in removing financial barriers to medical care, there are still substantial social and cultural barriers to access in Western Europe and Canada, which result in significant disparities in the use of health services by social class (Rodwin 1987a).
3. Even in national health service (NHS) systems such as those in Britain, Sweden and Italy, where all residents are entitled to "free" health services, there are still social and cultural barriers to access. In Britain, where this issue has been scrutinized, studies have uncovered severe inequalities in the use of health care services by social class (Townsend and Davidson 1982).
4. One of the unanticipated side effects of NHI and NHS systems has been to reinforce the institutional structure of a traditional health care delivery system that separates hospital-based care from community-based ambulatory services. Beyond strengthening government regulation, NHI, in particular, has promoted and strengthened the fee-for-service practice of medicine.
5. Policymakers in all Western industrialized nations have recognized the need to shift the balance of care from hospitals to less costly community care settings, but no country has succeeded in making significant resource shifts in this direction.

6. No country has resolved the so-called "cost crisis" in medicine. Whether health care expenditures amount to a high proportion of gross domestic product (GDP), as in the United States, or to a relatively low proportion of GDP, as in Canada and especially Britain, policymakers have attempted to reduce their rate of increase.¹²

Given the range of common problems in different health systems, what is most striking about how they are currently dealt with abroad is the extent to which a number of fashionable American themes have drifted north to Canada and across the Atlantic to Western Europe. The idea of privatization has provoked heated debate. Also, there is interest in making consumers finance a larger share of health care costs and in adapting Diagnosis-Related Groups (DRGs) to refine the budget allocation process for hospitals. Above all, HMOs have attracted the greatest attention from specialists in the health policy field.

Virtually no one in Canada or Western Europe views the American health system as a model to emulate. Even under the government of Prime Minister Thatcher there is no significant challenge to the principle of an NHS in Britain (Klein 1985). Nor is there any question about eliminating NHI in such countries as France, Germany, Belgium or the Netherlands. But there is great interest, in some quarters, in testing American innovations for health care delivery, in designing policy experiments, and in introducing reforms at the margins of these systems.

To the extent that the insertion of HMOs into either the NHI or NHS systems represents an American "solution" to *foreign* problems, it may, paradoxically, have more practical implications for the United States. For this reason, it is worthwhile reviewing a number of proposals currently under discussion abroad. Such an approach can provide insights as to how elements of American exceptionalism in the health sector could be turned into an immense advantage.

HMOs: AN INNOVATIVE IDEA FOR HEALTH POLICY ABROAD

Why the interest in HMOs and recent American policy themes? It may be explained partly as a reaction to the rigidity of NHI and NHS systems and partly as a search for greater flexibility. It may also reflect a disillusionment with previous sweeping reforms that were supposed to solve health sector problems but failed to meet all of their ambitious goals. Or, it may be no more than a fascination with American fashion—a case of keeping up with the latest acronyms! Whatever the explanations for this interest, the idea of introducing HMOs into national systems that provide universal entitlement to health care usually involves two reforms.

It spurs policymakers to combine regulatory controls with competition on the supply side, and it encourages them to design market incentives for both providers and consumers of health care. Let us consider some examples in France, Canada and Britain.

FRANCE: LES RESEAUX DE SOINS COORDONNES (RSC)

France is noted for combining NHI with fee-for-service private practice in the ambulatory care sector, and a mixed hospital sector of which two-thirds of all acute beds are in the public sector and one-third in the private sector (Rodwin 1981). Physicians in the ambulatory sector and in private hospitals (known as *cliniques*) are reimbursed on the basis of a negotiated fee schedule. Roughly 15 percent of all physicians are allowed to set their own fees. Physicians based in public hospitals, the principal teaching and research institutions, are reimbursed on either a part-time or full-time salaried basis. Private *cliniques* are reimbursed on the basis of a negotiated per diem fee. Public hospitals used to be reimbursed on a retrospective cost-based per diem fee, but they have received prospective budgets since 1984.

There are several problems in this system. From a public health point of view, there are inadequate linkages between public hospitals and primary care physicians. Although general practitioners in the fee-for-service sector have informal referral networks to specialists and public hospitals, there are no formal institutional relationships which assure continuity of care, disease prevention and health promotion services, posthospital follow-up care, and systematic quality controls.

From the point of view of economic efficiency criteria, the problems of the French health care system are not unique. On the demand side, two factors encourage consumers to increase their use of medical care services: the uncertainty about the results of treatment and the presence of insurance coverage. In order to reduce the risk of misdiagnosis or improper therapy, physicians are always tempted to order more diagnostic tests. Since NHI covers most of the cost, there is no incentive, either for the physician or for the patient, to balance marginal changes in risk with marginal increases in costs. This results in excessive medical care utilization.

On the supply side, fee-for-service reimbursement of physicians has provided incentives to increase their volume of services so as to raise their income. Likewise, per diem reimbursement of *cliniques* and hospitals created incentives to increase patient lengths of stay. Prospectively set hospital budgets (known as "global budgets") have eliminated this

problem in France but they represent a blunt policy tool, one which tends to support the existing allocation of resources within the hospital sector and, possibly, to jeopardize the quality of hospital care. It is relatively easy for a hospital to receive an annual budget to maintain its ongoing activities, but it is extremely difficult to receive additional compensation for higher service levels, institutional innovations or improvements in the quality of care. Even with prospective budgets, hospitals naturally seek to maximize the level of their annual allocations and to resist budget cutbacks.

In summary, providers under French NHI have no financial incentives to achieve savings while holding quality constant or even improving it. Consumers have few incentives, other than minimal copayments, to be economical in their use of medical care. And, there are no incentives to move the French system away from hospital-centered services toward new organizational modalities.

Traditional solutions to these problems go in the direction of forcing patients to pay higher copayments. For example, a three-dollar daily copayment charge was recently imposed on all hospital inpatient stays. Reimbursement for drugs has become more restrictive, particularly for those with more questionable therapeutic effects. Also, the government will surely allow more physicians to refuse assignment of their fees and engage in extra-billing. The problem with these proposals is that they focus only on the demand side. They do nothing to promote supply-side efficiency. It is in response to this challenge that a proposal was recently developed to introduce a system of HMOs under French NHI.

In French, the concept of an HMO was translated as a *réseau de soins coordonnés* (RSC)—a network of coordinated medical services. The proposal, published in the *French Review of Social Affairs* by two French economists, a French physician and the present author (Launois et al. 1985), is based on six principles:

1. *Preservation of Entitlements under NHI.* All compulsory payroll taxes for NHI remain unchanged. All those covered under French NHI, i.e., 99 percent of the population, remain covered. The current level of benefits becomes a minimum benefit package under the new plan.
2. *Supply-Side Modernization through the Creation of RSCs.* Qualified RSCs are required to provide minimum benefit packages and allow open enrollment. RSCs could be organized by a variety of sponsors. They would promote vertical integration in the health sector and would place hospitals, day surgery facilities, physicians and other health care profession-

als at risk for providing cost-effective medical services. Based on evidence from operating HMOs in the United States, this form of medical care organization is expected to reduce hospital admissions by as much as 40 percent when compared to traditional fee-for-service practice (Luft 1981).

3. *Promotion of Integrated Medical Care.* The RSC assumes a contractual responsibility for providing its enrolled population with all necessary health services. The patient chooses a primary care physician who is in charge of making proper referrals and managing patient care.

4. *Prepayment on a Capitation Basis.* The RSC receives a prepaid capitated monthly fee directly from the beneficiary's NHI fund. This payment is equal to the actuarial cost based on the enrollee's age, sex and health status. The RSC's annual budget is equal to its annual capitation payment multiplied by the number of its enrollees. Within that constraint, managers have an incentive to minimize costs and to maximize patient satisfaction so as to avoid disenrollment.

5. *Marginal Shifts in Health Care Financing.* Most of the capitated fee is financed directly by the beneficiary's NHI fund. Since consumers pay roughly 20 percent of all health expenditures through copayments, there is an additional prepaid contribution by the beneficiary at the time of enrollment to make the proposal financially viable. This would be equal to the difference between the capitation fee charged by the RSC and the actuarial cost calculated by the beneficiary's NHI fund. There is no payment at the time of service use, and all enrollees who cannot afford the additional contribution are eligible for a state subsidy.

6. *Competition between RSCs.* Enrollment in RSCs is voluntary. This results in three levels of competition. First, between RSCs and the traditional NHI. Second, between RSCs, themselves. Third, between health care providers to whom RSCs will send their enrollees, presumably on the basis of their ability to keep quality high and costs low.

The six principles of this proposal were inspired by Alain Enthoven's (1980) Consumer Choice Health Plan for the United States. But whereas Enthoven's plan is designed to create a new form of NHI for the United States, the RSC proposal is largely a strategy to promote supply-side efficiency within an already existing NHI system. As in the case of comprehensive medical plans (CMPs)—HMOs for Medicare beneficiar-

ies—in the United States, if French beneficiaries choose to enroll in an RSC they would lose their coverage under the traditional NHI. Just as CMPs would have to accept all Medicare beneficiaries who choose to enroll, all RSCs would have to accept all French NHI beneficiaries who choose to enroll, which could be 99 percent of the population. Thus, the problem of biased selection is somewhat reduced, although by no means absent.

CANADA: PUBLICLY FINANCED COMPETITION

Canada, like France, has an NHI system. But there are no copayments in Canada; there is first-dollar coverage for hospital and medical services. Physicians in ambulatory care are paid predominantly on a fee-for-service basis, according to fee schedules negotiated between physicians' associations and provincial governments. In contrast to France, physicians in hospitals are most often paid on a fee-for-service basis, as in the United States. Also, there are few private for-profit hospitals in Canada such as French *cliniques* and American proprietary or investor-owned institutions. Most acute care hospitals in Canada are private non-profit institutions. But their operating expenditures are financed through the NHI system, and most of their capital expenditures are financed by the provincial governments.

In the United States, Canada's health system is typically depicted as a model for NHI (Andreopoulos 1975). Its financing, through a complex shared federal and provincial tax revenue formula, is more progressive than the European NHI systems that are financed on the basis of payroll taxes. Canada's levels of health status are high by international standards, and the system has achieved notable success in controlling the growth of health care costs. What, then, are the problems in this system?

From the point of view of health care providers, there is, above all, a crisis of underfinancing. Physicians complain about low fee levels. Hospital administrators complain about draconian control of their budgets. And other health care professionals note that the combination of a physician "surplus" and excessive reliance on physicians prevents an expansion of their rôles. Although Robert Evans (1987) contends that Canadian cost-control policies cannot be shown to have jeopardized the quality of care, providers and administrators, alike, claim that there has been deterioration since the imposition of restrictive prospective budgets.

Leaving aside the issue of quality, the same issues discussed in the context of France are present in Canada with respect to economic efficiency. Neither the hospital physician nor the patient has an incentive to be economical in the use of health care resources. On the demand side, since patients benefit from what is perceived as "free" tax-financed first-dollar coverage, they have no incentive to choose cost-effective forms of

care. For example, in the case of a demand for urgent care, there is no incentive for a patient to use community health centers rather than rush directly to the emergency room.

On the supply side, physicians lack incentives to make efficient use of hospitals which are essentially a free good at their disposal. There are no incentives for altering input mixes to affect practice style (technical efficiency). Nor are there incentives for providers to evaluate service levels and the kinds of therapy performed in relation to improving health status (allocative efficiency). It could be argued that these problems are common to all health systems. But they are especially acute in a system characterized by a bilateral monopoly that tends to support the status quo. On the one hand, providers have strong monopoly power which they use to defend their legitimate interests; on the other, the monopsony power of sole source financing (under Canadian NHI) keeps provider interests in check at the cost of not intervening in the organizational practice of medicine.

Stoddard has characterized the problems of the Canadian health system as "financing without organization". In his view, Canadian provinces "adopted a 'pay the bills' philosophy, in which decisions about service provision—which services, in what amounts, produced how, by whom, and where—were viewed as the legitimate domain of physicians and hospital administrators" (Stoddard 1984, p. 3). The result of this policy is that provincial governments were concerned about maintaining a good relationship with providers. This concern has not avoided tough negotiations and occasional confrontations. But there has been no effort to devise new forms of medical care practice, e.g., HMOs or new institutions to handle the growing burden of long-term care for the elderly. The side effect of Canadian NHI has been to support the separation of hospital and ambulatory care and to reinforce traditional organizational structures.

As in France or the United States, there are, in essence, two strategies for managing the Canadian health system and making adjustments. The first involves greater regulation on the supply side—even stronger controls on hospital spending, more rationing of medical technology, more hospital closures and mergers, and eventual prohibition of extra-billing. The second involves increased reliance upon market forces on the demand side—various forms of user charges such as copayments and deductibles now advocated as forms of privatization. Neither strategy is likely to succeed on its own. The former will control health care expenditures in the short run but it fails to affect practice styles. Its effectiveness runs the risk of exacerbating confrontation between providers and the state and jeopardizing health care needs. The latter deals with only part of the problem, the demand side, and neglects the issue of supply-side

efficiency. It provides no mechanism by which consumer decisions can generate signals to providers to adopt efficient practice styles. Moreover, it is likely to raise the level of total (public and private) expenditures.

Due to the deficiencies which may occur if each strategy is followed independently, Stoddard (1982) has devised an innovative proposal for the province of Ontario, one that relies on the use of market forces while maintaining the full benefits of a compulsory and universal NHI program. His proposal, which he calls "Publicly Financed Competition", rests on four principles:

1. *Creation of Three Payment Modalities on the Supply Side.* Physicians would have the choice of practicing in solo or group practice in the fee-for-service modality, or accepting a capitation fee per person enrolled in their practices, or accepting salary payment in return for working in community health centers organized by the public sector. Fees in the fee-for-service modality would correspond to the current fee schedule and extra-billing would be allowed to continue. The capitation rate would be based on the average cost of insured services per patient across all three payment modalities. Salaries, as well as staffing, programs and service mix in the community health centers would be set by Ministry of Health planners.
2. *Financing of NHI Is Unchanged.* All citizens would pay for health care through premiums and taxes as they do currently.
3. *Choice of Primary Care Provider.* All citizens would continue to choose a primary care provider, but they would have to commit themselves to the selected provider for a specified period of time. The NHI program would no longer cover services not sought from or approved by the primary care provider. All services used by each patient over the course of the year would be charged to the appropriate payment modality.
4. *Calculation of Premium for Each Payment Modality.* At the end of each enrollment period, the premium for each modality would be adjusted, based on its total costs. The least costly modality would then become the baseline which would be fully covered under the Ontario Health Insurance Plan. Patients enrolled in the two more costly modalities would themselves have to pay the difference between the baseline and the higher premium.

Although these principles are not as elaborately developed as the French RSC model, they are equally provocative and present a serious

challenge to the status quo. Since the relative premiums of the three modalities are calculated on the basis of the average per capita cost *including* hospital utilization, there would be powerful incentives to reduce such utilization. Assuming that government measures are taken to assure minimum levels of medical care quality across payment modalities, these four principles create a system in which the patient benefits from seeking an efficient provider and the provider benefits by choosing cost-effective styles of practice. The level of health benefits remains the same across the three modalities; access to care would not be impeded by user charges; and adverse selection between payment modalities would be carefully monitored by requiring open enrollment and eventually introducing premium adjustments which would take into account age, sex and health status.

BRITAIN: INTERNAL MARKETS AND HMOS

Britain is the exemplar of an NHS. It is financed almost entirely through general revenue taxation and is accountable directly to the Department of Health and Social Security (DHSS) and Parliament. Access to health services is free of charge to all British subjects and to all legal residents. But despite the universal entitlement, Britons spend only 5.5 percent of their GNP on health care—one-half of what Americans spend as a percentage of their GNP.

Although the NHS is cherished by most Britons, there are, nevertheless, some serious problems concerning both the equity and efficiency of resource allocation in the health sector. With regard to equity, the Resource Allocation Working Party in 1976 developed a formula (RAWP) for the allocation of NHS funds among regions (Great Britain DHHS 1976). The formula represents one of the most far-reaching attempts to allocate health care funds because it incorporates regional differences in measures of health status. Slow progress is now being made in redistributing the aggregate NHS budget along the lines of RAWP, but substantial inequities still remain both from the point of view of spatial distribution and from the point of view of social class (Townsend and Davidson 1982).

With regard to efficiency, the problems are even more severe because NHS resources are extremely scarce according to international standards. Since there is less slack, the marginal costs of inefficiency are higher than in Western Europe or the United States. And since the NHS faces the same demands as other systems to make available new technology and to care for an increasingly aged population, British policymakers recognize that they must pursue innovations that improve efficiency. But there are numerous institutional obstacles in the way.

The tripartite structure of the NHS is, itself, a major source of inef-

iciency. Regional Health Authorities (RHAs) are responsible for allocating budgets to hospitals in their regions. Hospital-based "consultants" are paid on a salaried basis with distinguished clinicians receiving "merit awards", and all consultants have the right to see a limited number of private fee-paying patients in "pay beds". Outside the RHA budget are Family Practitioner Committees (FPCs) responsible for remunerating general practitioners (GPs), ophthalmologists, dentists and pharmacists. The GPs are reimbursed on a capitation basis with additional remuneration coming from special "practice allowances" and fee-for-service payment for specific services, e.g., night visits and immunizations. Separate from both the RHAs and the FPCs are the local authorities (LAs) that are responsible for the provision of social services, public health services and certain community nursing services.

Such an institutional framework creates perverse incentives to shift borderline patients from GPs to hospital consultants, to the community, and back to the hospital. GPs, for example, have no incentive to minimize costs and can impose costs on RHAs by referring patients either to hospital consultants or for diagnostic services. NHS managers can shift costs from the NHS to social security by sending elderly hospitalized patients to private nursing homes. And, consultants can shift costs back onto the patient by keeping long waiting lists thereby increasing demand for their private services. As in France and Canada, neither the patient nor the physician in Britain bears the costs of the decisions they make; it is the taxpayer who pays the lion's share of the bill.

Three recent strategies, all of them inadequate, have attempted to deal with this problem.¹³ The first came promptly with the arrival of the Thatcher government. After cautious attempts to denationalize the NHS by promoting a shift toward NHI and privatization, the conservative government backed off when it realized that such an approach would not merely provoke strong political opposition but would also increase public expenditure and, therefore, conflict with its budgetary objectives (McLachlan and Maynard 1982). Instead, the strategy was narrowed in favor of encouraging competition and market incentives in limited areas. To begin with, the government allowed a slight increase in private beds in NHS hospitals. In addition, it introduced tax incentives to encourage the purchase of private health insurance and the growth of charitable contributions. Also, the government encouraged local authorities to raise money through the sale of surplus property and to contract out to the private sector such services as laundry, cleaning and catering.

The second response was the Griffiths Report, which resulted in yet another reorganization in the long history of administrative reform within the NHS. Mr. Griffiths, the former director of a large English department store chain, introduced the concept of a general manager at the Depart-

ment (DHSS), Regional, District and Unit levels. This individual is now presumably responsible for the efficient use of the budget of each level of the NHS. The problem, however, is that the tripartite structure of the system remains unchanged; the general managers have very little information about least-cost strategies (across the tripartite structure) for generating improvements in health status.

The third and most recent response to the problem of improving efficiency has been to reduce the drug bill. Since April of 1985, the government has limited the list of reimbursable drugs and has reduced the pharmaceutical industry's rate of return. These measures will help contain the costs of the only open-ended budget within the NHS. But there is no evidence that they will have any impact on the efficiency of health care expenditures.

The more innovative efficiency-improving ideas have been developed by Enthoven and Maynard. They concern the promotion of "internal markets" and HMOs within the existing system of entitlements provided under the NHS. The essence of these ideas is to create financial incentives for each District to provide its residents with the best medical care possible, even if it has to purchase services outside its boundaries. The aim is to maximize the benefits of health service expenditures, as measured by some measure of health status, e.g., quality-adjusted life years (QALYs), or to minimize the costs of sustaining a given level of QALYs. It sounds entirely theoretical but cost-effectiveness studies can produce empirical results. Recent findings indicate that the cost of a QALY of hemodialysis in a hospital is 14 times that of a coronary artery bypass graft and more than 15 times that of a hip replacement (Torrance 1984; Williams 1985).

Short of allocating the entire NHS budget so as to maximize QALYs, there are a number of efficiency-improving measures that could be taken in the short run. For example, to avoid long queues for elective surgery in some regional areas and excess capacity in others, incentives could be devised to reward those regions that receive what the British call "cross-boundary flows". Or, in order to persuade GPs to prescribe economically, a system could be devised to allow GPs to share in the savings. Beyond these examples of internal markets, Enthoven and Maynard have proposed variations of an HMO plan for the NHS.

In Enthoven's plan, which he considers a form of "market socialism", a District continues to receive an RAWP-based per capita revenue and capital allocation and remains responsible for providing health services to its resident population (Enthoven 1985). In contrast to the present system, however, it receives additional compensation for services provided to residents from other districts and it controls referrals to providers out-

side its district. In short, the District controls all budgets within the tripartite structure and purchases health services from the most cost-effective sources outside its borders. In effect it operates as an HMO. Consultants and GPs enter into a variety of contractual arrangements with District Authorities, and District Authorities are free to enroll consumers near the borders of a neighboring district.

In Maynard's plan, the GP functions as a client budget holder (Maynard 1984, 1985). All Britons receive a voucher from the NHS which entitles them to sign up with a GP of their choice. The voucher generates a per capita payment to the GP in return for the provision of comprehensive health care for a year, after which the patient can choose another GP. The GP is responsible not merely for providing primary care but also for purchasing hospital services from public or private hospitals.

Both plans would provoke rapid reorganization of the health sector in Britain. The Enthoven plan would shift power to District managers—far more than they now exercise following the Griffiths reforms. The Maynard plan would shift power to GPs who would need to hire managers to assist with HMO formation. Needless to say, the details of these plans require a great deal more study. But even at such a level of generality, what is most interesting is the extent to which they resemble new ideas in France and Canada.

THE UNITED STATES IN RETROSPECT

There is currently a dynamism in the health care sector in the United States, which has no parallel in either Western Europe or Canada. Business corporations and third-party payers are organizing themselves into prudent purchasers of health care, and are demanding that providers both produce more information on the results of their services and reduce their costs while holding quality constant. Under such pressure, providers are responding by forming vast multi-institutional hospital systems, as well as vertically integrated systems such as HMOs that combine health insurance with the provision of health services not merely in hospitals but before entering them and after being discharged.

The industrial restructuring of the health sector in the United States is not the outcome of a national plan or policy. It corresponds more closely to what Joseph Schumpeter (1942) called "the process of creative destruction"—that inexorable drive of capitalism to create new modes of economic organization and to destroy old ones. In this process, many hospitals will not survive (Goldsmith 1981). Many physicians will be forced to

change their practice styles. And there is likely to be improved coordination between primary, secondary and tertiary levels of health care.

Paradoxically, such an outcome corresponds to what health planners have been promoting for over half a century. There is one difference, however. Health planners never anticipated that newly emerging health care institutions would be under pressure to behave like business organizations. Is it possible, in such an environment, to expect that HMOs and other alternative delivery systems will serve the growing number of uninsured individuals?

The answer, I think, is yes, but not until we, as a society, agree to reimburse providers for their services to the uninsured. Morone and Dunham (1985) argue that the new DRG reimbursement system under Medicare will produce pressures to shift costs to other payers which will, in turn, lead to an all-payer DRG system. Add to that a tax to cover the costs of uncompensated care and we will inadvertently be "slouching towards NHI". The scenario is compelling and the political analysis is shrewd but, even if the predictions hold, the result will be a system that only ensures hospital payment for all. This may be good for the hospital industry but it will not provide primary care to the uninsured. Nor will it be compatible with the trend toward vertical integration in the health sector. A more probable scenario is for all payers to encourage capitated forms of medical care reimbursement, e.g., risk contracting under Medicare, which is growing rapidly. In this respect, the issues raised by introducing the idea of HMOs in France, Canada and Britain are helpful in reflecting about health policy at home.

The French plan for RSCs, the Canadian proposal for publicly financed competition and British-American ideas about internal markets and HMOs focus on combining the best of both worlds—the supply-side efficiency embodied in a well-managed HMO along with the financial security of a universal NHI system. Such policy proposals suggest that it may be possible to avoid the undesirable side effects of an NHI or an NHS system that reinforces an institutional separation between hospital-based and ambulatory health care services and provides no incentives for efficiency in the allocation of health care resources. It appears to be easier in the United States than in Western Europe or Canada to create new institutions such as HMOs, which potentially can improve linkages between levels of care and provide incentives for efficiency. And it is relatively easy for some HMOs to thrive in a system that allows multiple strategies for favorable selection of risks. But how does one compensate for biased selection in health insurance (Luft 1986) and also assure that HMOs will thrive under a universal and compulsory NHI system? The proposals we have examined suggest that this would require a critical

role for the state in devising proper rules for competition and in enforcing them.

How should the rules of the competitive game be devised and periodically revised to encourage new health care institutions to meet public policy goals? How can the quality of medical care be systematically assessed in HMOs? How can contracting out by public institutions be properly monitored? And how can premium payments to HMOs be adjusted to assure that they have incentives to serve all beneficiaries—even those who are at high risk? These are the key questions which emerge from a cross-national comparison of three variations on an innovative American idea—the HMO. As we decide whether to maintain or enlarge existing entitlements to health care for Medicare and Medicaid beneficiaries, and eventually for the uninsured, the debate about health policy in the United States is likely to revolve around these same questions.

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NOTES

1. Estimates of the uninsured range from 15 percent to 20 percent of the population. In 1984, the *Current Population Survey* estimated that 35.1 million people, 17.1 percent of the population under 65, were without insurance. The percentage increases if one broadens the definition to include the underinsured and otherwise medically disadvantaged. See M. B. Sulvetta and K. Swartz, *The Uninsured and Uncompensated Care: A Chartbook* (Washington, D.C.: National Health Policy Forum, George Washington University, June 1986).
2. There has been no debate in the literature on this point. My impression is that this presumption constitutes the prevailing view in health policy circles.
3. In his book, *Imperial Germany and the Industrial Revolution* (New York: Macmillan, 1915), Veblen refers to the “merits of borrowing” and to the “penalty of taking the lead”. He used these concepts to show that Imperial Germany drew many advantages from its state of relative backwardness. See selected chapters in *The Portable Veblen*, ed. M. Lerner (New York: Viking Press, 1958).
4. Alexis de Tocqueville, *Democracy in America* (New York: Alfred A. Knopf, 1948). Cited by L. Hartz, *The Liberal Tradition in America*, 35.
5. Interpretations of American exceptionalism are wide-ranging. But there is surprising consensus—both on the Left and on the Right—concerning the unique

character of the American historical experience. Frederick Jackson Turner's "frontier thesis" attributed American distinctiveness to westward expansion. Werner Sombart attempted to explain the failure of socialism in America by emphasizing the success of American capitalism. Selig Perlman (1928) pointed to the ethnic cleavages among the immigrant working class. Hartz (1955) emphasized the absence of feudalism and the importance of the liberal tradition in America. He called attention to basic American values—rugged individualism, a distrust of government, and a faith in liberalism. Lipset (1963) emphasized the relatively low level of status differentiation in the United States compared to that of Europe. A good summary of these issues may be found in *Failure of a Dream: Essays on the History of American Socialism*, eds. J. M. Laslett and S. M. Lipset (Garden City, N.Y.: Anchor Press, 1974); and M. Harrington, "The American Exception." In *Socialism*, chap. 6 (New York: Bantam Books, 1970).

6. For an equally provocative albeit different interpretation of this issue, see T. Halper, "Life and Death in a Welfare State: End-Stage Renal Disease in the United Kingdom," *Health and Society: Milbank Memorial Fund Quarterly* 63 (Winter 1985): 52–93.

7. This change of policy was prompted by the 1977 U.S. Supreme Court decision in *Bates v. State Bar of Arizona* (433 v.s. 350) allowing health care professionals to engage in advertising.

8. The rationale for this response is expressed eloquently in James Madison's Tenth Federalist Paper. See *The Federalist Papers* (New York: The New American Library, Inc., 1961).

9. See "Comparative Health Systems: Notes on the Literature," in V. Rodwin, *The Health Planning Predicament*, 239–48.

10. The completed edition of this monograph focuses less on policy learning and more on presenting an overview of how hospitals are paid in Switzerland, the Netherlands, France, Canada, England, and West Germany, and on some of the determinants of hospital costs. See W. A. Glaser, *Paying the Hospital* (San Francisco: Jossey-Bass, 1987).

11. For examples of this approach, see V. Rodwin, *The Health Planning Predicament*; J. de Kervasdoué, J. R. Kimberly, and V. G. Rodwin, eds., *The End of An Illusion*; G. McLachlan and A. Maynard, eds., *The Public/Private Mix for Health*. Also see C. Altenstetter, "Hospital Policy and Resource Allocation in the Federal Republic of Germany." In *Public Policy Across Nations: Social Welfare in Industrial Settings*, eds. A. Groth and L. Wade, 237–65 (Greenwich, Conn.: JAI Press, 1985); L. D. Brown, "Health Reform, Italian-Style," *Health Affairs* 3 (Fall 1984): 75–101.

12. There are two issues involved here. First, in terms of the percentage of societal resources devoted to health care, no one knows how much is enough. Second, in terms of the rate of growth of health care expenditures, policymakers in almost all Organization for Economic Cooperation and Development (OECD) countries have agreed that the rate of growth was too high during the period 1960–1975 and have successfully pursued policies to reduce it. George Schieber has analyzed the most recent and reliable expenditure data on this point by

distinguishing price effects from actual changes in what he calls the utilization/intensity of services. He shows that in the "big Seven" OECD countries both real annual expenditures and utilization/intensity per capita increased at over twice the rate during the 1960–1975 period than during the 1975–1983 period. This pattern holds for France, Germany, Italy, Japan and the United Kingdom, as well as for Canada and the United States. See G. J. Scheiber, "The Financing and Delivery of Health Care in OECD Countries: Past, Present and Future" (Tokyo: Joint Japanese/OECD Conference on Health and Pension Policies in the Context of Demographic Evolution and Economic Constraint, November 25–28, 1985). Also see G. J. Schieber and J. P. Poullier, "International Health Care Spending," *Health Affairs* 5 (Fall 1986): 111–22.

13. For more detail on recent developments in the NHS, see A. Maynard, "Annual Report on the National Health Service" (York: Centre for Health Economics, 1986).

REFERENCES

- Aaron, H. J., and Schwartz, W. B. (1984). *The Painful Prescription: Rationing Hospital Care*. Washington, D.C.: Brookings Institution.
- Abel-Smith, B. (1985). "Who Is the Odd Man Out? The Experience of Western Europe in Containing the Costs of Health Care," *Health and Society: Milbank Memorial Fund Quarterly* 63 (Winter): 1–17.
- Alford, R. R. (1975). *Health Care Politics*. Chicago: University of Chicago Press.
- Altenstetter, C. (1974). *Health Policy-Making and Administration in West Germany and the United States*. Beverly Hills: Sage Publications.
- Anderson, G. F. (1986). "National Medical Care Spending," *Health Affairs* 5 (Fall): 123–30.
- Andreopoulos, S., ed. (1975). *National Health Insurance: Can We Learn from Canada?* New York: John Wiley & Sons.
- Bendick, M., Jr. (1985). "Privatizing the Delivering of Social Welfare Services." In *Privatization*, Working Paper No. 6. Washington, D.C.: National Conference on Social Welfare.
- Brown, L. D. (1985). "Health Policy in the American Welfare State." Paper prepared for the Ford Foundation Project on the Future of the Welfare State.
- de Kervasdoué, J.; Kimberly, J. R.; and Rodwin, V. G., eds. (1984). *The End of an Illusion: The Future of Health Policy in Western Industrialized Nations*. Berkeley: University of California Press.
- Elling, R. H. (1980). *Cross-National Study of Health Systems*. 2 vols. Detroit: Gale Research Co.
- Enthoven, A. C. (1980). *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*. Reading, Mass.: Addison-Wesley.
- . (1985). "Reflections on Improving Efficiency in the National Health Service." Occasional Paper. London: Nuffield Provincial Hospitals Trust.
- Evans, R. G. (1984). *Strained Mercy: The Economics of Canadian Health Care*. Toronto: Butterworths.

- _____. (1985). "Illusions of Necessity: Evading Responsibility for Choice in Health Care," *J. of Health Politics, Policy and Law* 10 (Fall): 439-67.
- _____. (1987). "Holding the Line: The Canadian Experience with Global Budgeting." In *Système de santé, pouvoirs publics et financeurs: qui contrôle quoi?* eds. M. Berthod-Wurmser, V. G. Rodwin et al., 263-82. Paris: Documentation Française.
- Field, M. G. (1973). "The Concept of 'Health System' at the Macrosociological Level," *Social Science & Medicine* 7 (October): 763-85.
- _____. (1978). *Comparative Health Systems: Differentiation and Convergence*. Final report under Grant No. HS-00272. Rockville, Md.: National Center for Health Services Research.
- Fox, D. M. (1986). *Health Policies, Health Politics: The British and American Experience, 1911-1965*. Princeton: Princeton University Press.
- Glaser, W. A. (1970). *Paying the Doctor: Systems of Remuneration and Their Effects*. Baltimore: Johns Hopkins University Press.
- _____. (1978). *Health Insurance Bargaining: Foreign Lessons for Americans*. New York: Gardner Press.
- _____. (1982). *Paying the Hospital: Foreign Lessons for the United States*. New York: Center for the Social Sciences, Columbia University.
- _____. (1984). "Juggling Multiple Payers: American Problems and Foreign Solutions," *Inquiry* 21 (Summer): 178-88.
- Goldsmith, J. C. (1981). *Can Hospitals Survive? The New Competitive Health Care Market*. Homewood, Ill.: Dow Jones-Irwin.
- Great Britain, Department of Health and Social Security (1976). *Sharing Resources for Health in England*. Report of the Resource Allocation Working Party. London: HMSO.
- Hartz, L. (1955). *The Liberal Tradition in America*. New York: Harcourt, Brace and Co.
- Hollingsworth, J. R. (1986). *A Political Economy of Medicine: Great Britain and the United States*. Baltimore: Johns Hopkins University Press.
- King, A. (1973). "Ideas, Institutions and the Policies of Governments: A Comparative Analysis," *British J. of Political Science* 3 (No. 3): 291-313.
- Klass, G. (1985). "Explaining America and the Welfare State: An Alternative Theory," *British J. of Political Science* 15: 427-50.
- Klein, R. (1985). "Why Britain's Conservatives Support a Socialist Health Care System," *Health Affairs* 4 (Spring): 41-58.
- Launois, R.; d'Intignano, B. Majnoni; Stéphan, J. C.; and Rodwin, V. G. (1985). "Les réseaux de soins coordonnés (RSC): propositions pour une réforme profonde du système de santé," *Revue Française des Affaires Sociales* 1 (January-March): 37-61.
- Leichter, H. M. (1979). *A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations*. Cambridge: Cambridge University Press.
- Lipset, S. M. (1963). *The First New Nation: The United States in Historical and Comparative Perspective*. New York: Basic Books.
- Lowi, T. (1969). *The End of Liberalism*. New York: W. W. Norton & Co.

- Luft, H. S. (1981). *Health Maintenance Organizations: Dimensions of Performance*. New York: John Wiley & Sons.
- . (1985). "Competition and Regulation," *Medical Care* 23 (May): 383–400.
- . (1986). "Compensating for Biased Selection in Health Insurance," *The Milbank Quarterly* 64 (No. 4): 566–91.
- McLachlan, G., and Maynard, A., eds. (1982). *The Public/Private Mix for Health: The Relevance and Effects of Change*. London: Nuffield Provincial Hospitals Trust.
- Marmor, T., and Klein, R. (1986). "Cost vs. Care: America's Health Care Dilemma Wrongly Considered," *Health Matrix* 4 (Spring): 19–24.
- Marmor, T.; Bridges, A.; and Hoffman, W. (1978). "Comparative Politics and Health Policies: Notes on Benefits, Costs, Limits." In *Comparing Public Policies*, ed. D. Ashford, 59–80. Beverly Hills: Sage Publications.
- Maynard, A. (1984). "Budgeting in Health Care Systems," *Effective Health Care* 2 (No. 2): 41–49.
- . (1985). "HMOs in the NHS?" *Health Summary* 2 (February): 5.
- Mechanic, D. (1976). "The Comparative Study of Health Care Delivery Systems." Chap. 2 in *The Growth of Bureaucratic Medicine: An Inquiry into the Dynamics of Patient Behavior and the Organization of Medical Care*. New York: John Wiley & Sons.
- Morone, J. A., and Dunham, A. B. (1985). "Slouching Towards National Health Insurance: The New Health Care Politics," *Yale J. on Regulation* 2 (No. 2): 263–91.
- Perlman, S. (1928). *A Theory of the Labor Movement*. New York: Macmillan.
- Prottas, J.; Segal, M.; and Sapolsky, H. M. (1983). "Cross-National Differences in Dialysis Rates," *Health Care Financing Review* 4 (March): 91–103.
- Reinhardt, U. (1985). "Hard Choices in Health Care: A Matter of Ethics." In *Health Care: How to Improve It and Pay for It*, by L. Etheredge et al., 19–31. Washington, D.C.: Center for National Policy, April.
- Rodwin, V. G. (1981). "The Marriage of National Health Insurance and *La Médecine Libérale* in France: A Costly Union," *Health and Society: Milbank Memorial Fund Quarterly* 59 (Winter): 16–43.
- . (1984). *The Health Planning Predicament: France, Quebec, England, and the United States*. Berkeley: University of California Press.
- . (1987a). "Inequalities in Health in Public versus Private Systems: Britain, Canada, France and the U.S." In *Ethnicity and Health*, ed. W. Van Horne. Milwaukee: American Ethnic Studies Coordinating Committee, University of Wisconsin System. Forthcoming.
- . (1987b). "Le Contrôle des Pouvoirs Publics et des Payeurs: Comparaisons Internationales." In *Système de santé, pouvoirs publics et financeurs: qui contrôle quoi?* eds. M. Berthod-Wurmser, V. G. Rodwin et al., 55–68. Paris: Documentation Française.
- Roemer, M. I. (1977). *Comparative National Policies on Health Care*. New York: Marcel Dekker.
- Rosner, D. (1982). "Health Care for the 'Truly Needy': Nineteenth-Century

- Origins of the Concept," *Health and Society: Milbank Memorial Fund Quarterly* 60 (Summer): 355-85.
- Schumpeter, J. (1942). *Capitalism, Socialism and Democracy*. New York: Harper & Row.
- Starr, P. (1982). *The Social Transformation of American Medicine*, book 2, chap. 2. New York: Basic Books.
- Stoddard, G. (1982). "Publicly Financed Competition in Canadian Health Care Delivery: A Viable Alternative to Increased Regulation?" In *Proceedings of the Conference on Health in the '80s, and '90s and Its Impact on Health Sciences Education*, 173-84. Held in Montebello, Que., March 14-17. Toronto: Council of Ontario Universities.
- . (1984). "Rationalizing the Health Care System." Discussion paper prepared for the Ontario Economic Council Conference, "Ottawa and the Provinces: The Distribution of Money and Power," Toronto, May 14-15.
- Stone, D. A. (1980). *The Limits of Professional Power: National Health Care in the Federal Republic of Germany*. Chicago: University of Chicago Press.
- . (1981). "Drawing Lessons from Comparative Health Research." In *Critical Issues in Health Policy*, eds. R. A. Straetz, M. Liberman and A. Sardell, 135-48. Lexington, Mass.: D. C. Heath.
- Teune, H. (1978). "The Logic of Comparative Policy Analysis." In *Comparing Public Policies*, ed. D. Ashford, 43-55. Beverly Hills: Sage Publications.
- Torrance, G. W. (1984). "Health Status Measurement for Economic Appraisal." Paper presented at the Aberdeen meeting on Health Economics.
- Townsend, P., and Davidson, N., eds. (1982). *Inequalities in Health: The Black Report*. London: Penguin.
- Wilensky, H. L. (1975). *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures*. Berkeley: University of California Press.
- Williams, A. (1985). "Economics of Coronary Artery Bypass Grafting," *British Medical J.* 291 (August 3): 326-29.