

# Principles for a National Health Program: A Framework for Analysis and Development

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THE GROWING PROBLEMS OF ACCESS TO HEALTH services in the United States—37 million people without any health care coverage (analysis of March 1987 *Current Population Survey* data tape), millions more with inadequate insurance (Farley 1985), and continuing increases in the costs of care (*Health Care Financing Review* 1987)—have intensified the interest of health professionals, advocates of the uninsured, and public policy makers in major reforms to improve access. These developments in the health sector and their impact on political discourse have encouraged many people to believe that the United States may be closer to enacting a national health program (NHP) than at any time during the past decade.

But how do we decide what such a NHP should look like? Should we fill in the gaps in health insurance coverage, that is, develop programs to pick up where private insurance, Medicare, and Medicaid leave off? Should we mandate employers to provide private health insurance for their employees and dependents? Or should we transform health care financing and perhaps delivery to create a new social insurance program for health care? Is it possible to balance system reform of population coverage, benefits, and financing with political feasibility? These are merely a few of the alternative strategic and policy choices we must make if we are to fashion a program that

would meet the needs of society and that will have reasonably good prospects of being enacted.

A number of helpful analyses of alternative proposals were published when national health insurance (NHI) appeared to be "just around the corner" in the 1970s. Some of these analyses were really descriptive comparisons of bills in the Congress. For example, analyses published by the U.S. Congress, House of Representatives, Committee on Ways and Means (1971, 1974) and by the U.S. Department of Health, Education and Welfare (1976) compared NHI bills under nine subject or issue headings: general concept and approach, population coverage, benefits, administration, relation to other government programs, financing, standards for service providers, reimbursement of providers, and delivery and resources. These reports were helpful in comparing different bills, but they stopped short of analyzing the strengths and weaknesses of different approaches to each of these issues.

Another group of analyses focused on the alternative strategies for addressing the issues that must underly any NHP proposal. These authors discussed NHP issues within a set of analytic categories, and then usually examined some of the main NHI proposals according to this framework. For example, Somers and Somers (1977) addressed a variety of issues, including access, appropriate balance of types of services, physician supply, hospitals and other facilities, quality, and various economic issues. Davis (1975) analyzed the context within which national health insurance was then being considered and made a number of recommendations for general positions on population coverage, benefits, patient cost sharing, financing, payments to providers, and roles for private insurance companies, state governments, and consumers. Feldstein (1983, 535–53) specified several criteria by which NHI proposals should be judged—including beneficiaries and their income-related subsidies, incentives for efficiency in use of medical resources, and equity in financing—and then reviewed how well, in his view, alternative strategies would achieve these objectives. Others have analyzed some issues and options in the context of presenting their own proposals (e.g., Enthoven 1980; Fein 1986).

Feder, Holahan, and Marmor (1980) and their colleagues presented the most thorough discussion of NHP issues in lengthy separate chapters on administrative choices, physician reimbursement, health maintenance organizations (HMOs), physician supply and distribution, other health occupations, hospital payment and regulation, pa-

tient cost sharing, utilization controls, long-term care, prescription drugs, and dental care. Each chapter reviewed alternative policy strategies, their implications in the light of research evidence, and how some dominant bills dealt with these choices.

This article presents a less ambitious analysis of NHI issues than some of these earlier studies. Although it attempts to develop a framework for evaluating alternative NHP proposals, its framework also is intended to facilitate the development of a set of *principles* which might guide policy choices. Thus, rather than discussing administrative organization as a separate issue (Feder, Holahan, and Marmor 1980), it considers administration a subset of other issues—for example, whether a program should be universal or segmented in its coverage and whether resources should be allocated through the marketplace or by public planning processes. This approach is somewhat less applied and pragmatic, but it does keep discussion focused on the broader principles which implicitly or explicitly underly alternative NHP proposals and strategies. To illustrate the framework, the article examines four alternative proposals, selecting ones that represent very different strategies and principles.

### *Some Major NHP Strategies in the Late 1980s*

Broad national health program bills seem to compete with narrower incremental health care reform bills. In 1988, Congress enacted and President Reagan signed a catastrophic health insurance program as an expansion of Medicare, an incremental reform that still does not cover long-term care for the elderly and disabled. In the same session of the Congress, Sen. John Chafee (R-R.I.) introduced a bill to expand Medicaid to cover all people with family incomes below the poverty level and to allow those with incomes between 100 percent and 250 percent of the poverty level to buy into Medicaid on a sliding scale of cost. Sen. Edward Kennedy (D-Mass.) and Rep. Henry Waxman (D-Calif.) sponsored a broader proposal that would mandate all employers in the United States to provide health insurance to their employees who work at least half time, requiring them to provide a modestly comprehensive package of benefits and to pay at least 80 percent of the costs. The Kennedy-Waxman bill is also incremental because it would leave uncovered millions of people who work less than the minimum hours a week, are self-employed, or are not in

the labor force, and are not dependents of employees who meet the minimum-hours requirement.

More universal and comprehensive still is Rep. Edward Roybal's (D-Calif.) bill to establish national health insurance (NHI), which would cover the entire population through a program of comprehensive benefits, supported primarily by payroll taxes, with cost-controlled payments to providers and provisions to encourage HMOs as the health care delivery system of choice. The proposal that would require the most restructuring of the health system is Rep. Ronald Dellums's (D-Calif.) bill to create a national health service (NHS), which would provide comprehensive services through a government-owned and operated health system, financed by income, corporate, and payroll taxes, and in which all health professionals and workers would be salaried. The system would be governed by a bottom-up series of elected councils of NHS users and employees.

### *Important Dimensions of Health Systems*

I believe that seven dimensions would comprise the most important issues by which these and other health care reform proposals may be judged. Considering each dimension as a continuum along which various positions may be arrayed, alternative proposals could be compared along each continuum, albeit more approximating their relative relationships than precisely locating them along the continuum. This framework would emphasize the relativity of alternative positions, perhaps encouraging negotiation and compromise among stakeholders while facilitating assessments of how well a proposal achieves desired goals or principles. Advocates would continue to disagree, but analytically and explicitly comparing proposals on the basis of principles might enable the general public as well as professionals to participate in a more informed political process.

Two dimensions describe the basic shape of the proposed health program: inclusiveness of population coverage, and the comprehensiveness of benefits. Three dimensions characterize how economic resources would be generated and applied to health care: methods of financing and their progressivity, the efficiency with which resources are used, and the extent of planning and market forces in the allocation of resources. One dimension describes the alternatives by which those who are intended to benefit from the program may hold services

accountable. Finally, one dimension assesses the political feasibility of the proposal. I will describe and discuss each dimension, and briefly characterize the four national legislative proposals—the Chafee, Kennedy-Waxman, Roybal and Dellums bills—according to each dimension.

## The Shape of Health Systems and Programs

To users of health services, nothing defines a health program as fundamentally as who it covers and what benefits it provides.

### *Inclusiveness of Population Coverage*

Population coverage by any health program may range from completely *universal*—which in its most extreme form would include 100 percent of the population within a single program, financing system, and package of benefits—to completely *segmented*, in which there would be no third-party programs at all, and in which all members of the population would be individual participants in a health care marketplace. Using a more limited and familiar definition of segmentation, the population would be divided into many different programs with different characteristics. A somewhat more limited version of universalism would provide identical benefit packages to people who are covered by taxes paid by their employer, those who are covered by Social Security, those who are covered under welfare-based programs, and those who are unemployed and ineligible for either Social Security or federally assisted welfare programs. Any identification card used in the system would make no distinction between people based on the source of their coverage.

At the other end of the continuum would be a segmented system, in which such people would be covered by different programs with different benefit packages and different identification cards to distinguish them. Segmentation now characterizes health care in the United States: Medicare for the elderly and many disabled; separate Medicaid programs (each with its own eligibility levels and benefits) for welfare recipients and many, but not all, the poor in each state; a variety of indigent care programs in the states (although very few include any form of entitlement); many thousands of private health insurance plans

(predominantly self-insured employer plans and others that rely on HMOs, preferred provider organizations, and other managed care arrangements), with different benefit packages, costs, sources of care, and methods of payment; and no coverage at all for about 37 million people.

The most important differences among these myriad programs and plans are based on the source of financing—whether coverage is paid for by employers, by individuals, by Medicare (from a combination of Social Security taxes and general revenues), or by welfare programs (from a variety of federal, state, and local taxes)—and the benefit packages which differ roughly according to the type of financing. Private group insurance paid for by employers generally provides the best access to comprehensive benefits and high quality care, while Medicaid coverage, which is a welfare program available to some of the poor, provides variable benefit packages (because benefits are set by the states), variable quality of care (depending on provider participation and state regulation), and generally poor access to care (because low reimbursement rates and bureaucratic controls discourage provider participation). Just as racially segregated facilities and programs are never equal, neither do segmented programs provide equitable access or quality of care to the poor.

Programs that segment the poor also isolate the programs and render them politically vulnerable. The differing vulnerability of Medicaid and Medicare to budget cuts exemplifies these differences. In the first couple of years of the Reagan administration, the budgetary ax fell disproportionately on Medicaid and other health programs for the poor, who are not well organized, do not vote in large numbers, and remain politically powerless. During this same period, Medicare was better able to resist major cuts because it serves all elderly people—a group that includes all social classes, that is politically organized, and that “votes their interests” in large numbers (Brown 1983). Even the introduction in 1983 of prospective payment for hospitalization of Medicare beneficiaries was directed primarily at providers and was not expected to affect patients adversely, although it has had that effect as well (Brown 1987). Other differences are also important—including the federal character of Medicare in contrast to Medicaid’s administration by the states and the reliance of Medicare hospitalization insurance on a dedicated Social Security tax in contrast to Medicaid’s complete dependence on federal and state general tax rev-

enues—but the effect of broader and more powerful political support for Medicare suggests the importance of this issue in shaping a future NHP.

*Experience vs. Community Rating.* In addition to the segmentation between public and private sources of coverage, private health insurance itself has segmented coverage by “experience rating.” Experience rating segments the population into low-risk groups with low premium costs, to whom the industry heavily markets its insurance products through employers, and a smaller number of high-risk individuals who become virtually uninsurable because of the high premiums charged for them. Experience rating is opposed to “community rating,” in which high-cost groups are included with the much larger number of low-cost groups, with premium rates averaged across this population.

Blue Cross and Blue Shield began as not-for-profit carriers that marketed health insurance strictly on a community-rated basis. Commercial insurance companies, which entered the field during the 1940s and 1950s, used experience rating to lure employers by offering favorable-risk groups lower premiums than are possible under community rating. Their competition ultimately forced the Blues also to adopt experience-rated premiums. Experience rating has made health insurance unaffordable to many people, relegating the elderly, the disabled, and the poor to the public sector, to private charity care, or to no care at all. The experience in the United States amply demonstrates, that, in any insurance system, experience rating drives out community rating, leading to segmentation of the insurance market and the exclusion of a growing proportion of the population (Fein 1986, 10–32). Thus, an insurance system based on community rating would promote universalism while one that allows experience rating would promote segmentation.

*Means Tests.* “Means tests” have also contributed to the segmentation of health care by screening out the nonpoor from access to free or reduced-fee health services in both the public sector and private charity care. Throughout the early part of this century, charity and public hospitals and clinics were under heavy pressure from the medical profession to prevent anyone but the poorest members of society from using their free services (Rosner 1982, 146–63). Following this welfare tradition, most public and charity providers and all Medicaid programs use eligibility procedures to obtain financial information—

usually in great detail—from an applicant and determine whether the applicant meets the test of poverty established for the program. Recognizing that the poor are shut out of mainstream care by price rationing, means tests have been used to assure that none but the “deserving” poor would have access to subsidized care.

Is it inevitable that means tests would segment a national health program? Not necessarily. If a means test were to be used to exclude the nonpoor from a program available only to the poor, then it would tend to isolate the poor in a segmented (and vulnerable) program. If, however, a means test were used to determine eligibility for a subsidy to enable low-income people to participate in a universal program that required financial contributions as a condition of enrollment, then it would actually make the program more universal. A universal program financed by taxes, instead of by insurance premiums, could avoid means tests altogether if the taxes were paid on income or earnings and eligibility for the health program were considered an entitlement, not dependent on one’s ability to pay premiums.

The segmentation of the population into many different programs increases administrative complexity, requiring separate rules and procedures for different programs, including separate eligibility criteria. Enforcing these different rules, regulations, and eligibility conditions makes information about and understanding of the system less accessible to consumers, providers, and even administrators, and requires more elaborate administrative structures and greater cost than less complex administration. Therefore, a universal program may reduce administrative costs and complexity, although this potential could be easily thwarted by elaborate systems of administrative control and regulation.

*NHP Proposals.* Both the Dellums and Roybal bills would provide universal coverage; every resident in the country would be eligible, regardless of whether they are employed or not, poor or more affluent. The Kennedy-Waxman bill, on the other hand, would cover only the working population that is employed at least 17.5 hours per week and their dependents, leaving more than one-third (or 14 million) of the uninsured people still without coverage (Statement of Edward M. Gramlich, Congressional Budget Office, Nov. 4, 1987). The Kennedy-Waxman bill would eliminate experience rating for employers by requiring community rating for health plans that sell to them, but it would not eliminate experience rating from the health



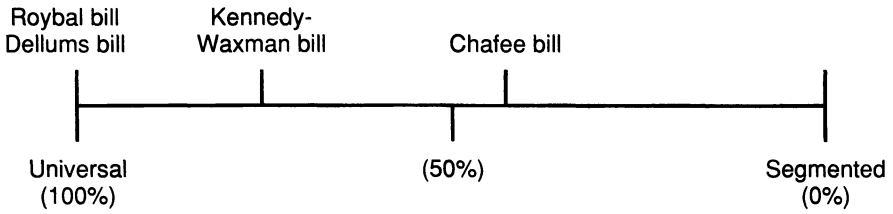


FIG. 1a. Inclusiveness of population coverage in proposed program

insurance system. The Chafee bill would cover only the lower-income population—the very poor to lower-middle-income working groups—employing a means test to keep out more affluent people. Figure 1a displays the inclusiveness of population coverage by each program.

When added to existing coverage of the population, however, both the Kennedy-Waxman and Chafee bills would represent a step toward more universal coverage of the population, albeit with continuing segmentation into multiple programs. Total population coverage, including other public and private sources, following enactment of the bills and assuming no major reductions or increases in coverage by other sources, is displayed in figure 1b. This incremental, patchwork approach to achieving universal health insurance coverage, what Marmor, Feder and Holahan (1980) called “national health insurance by aggregation,” has many obstacles to overcome before reaching that goal.

Including the entire population in one program is probably necessary to promote equity in health care, if equitable access is interpreted to mean that available health services should be distributed within the population on the basis of need, irrespective of income or

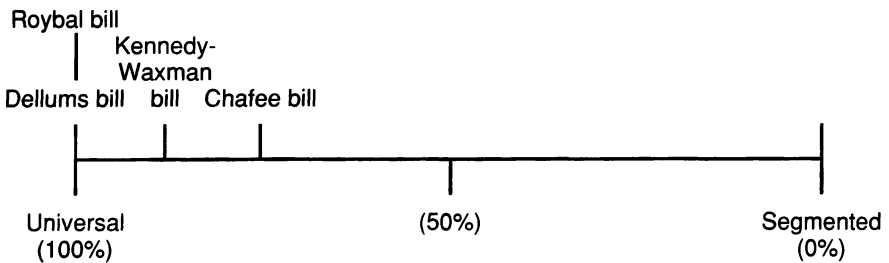


FIG. 1b. Inclusiveness of total population coverage of proposed program and other third-party coverage

wealth. Multiple programs and plans probably would perpetuate the current multitiered system of health care (Long 1987), even if that system assured "an adequate level" of health care for everyone, as the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983, 18-21) recommended in adopting an alternative interpretation of equity. This minimum floor would necessarily accept inequalities in access, leaving the low-income population in a lower tier of the health system.

State health insurance and state administration of national health insurance, although attractive for their responsiveness to local interests, share with patchwork national programs many of the risks of inequalities in access and benefits and inefficiencies in administration. The Medicaid program has taught us a good deal about potential weaknesses in letting the states determine benefits and eligibility standards and administer complex programs. If a program is universal (not just for the poor), administratively relatively simple (unlike the complex and mysterious Medicaid programs), and provides adequate federal funding and a solid floor for all programs, however, then some states may administer a national health insurance program very well. A basic system of national administration with an option for "selective state administration" would enable a national health insurance program to be flexible enough to respond to states with demonstrated commitment to providing equal access for low-income groups and with a record of competent program administration (Feder and Holahan 1980).

### *Comprehensiveness of Benefits*

How comprehensive should a NHP be? Should the minimum package of benefits include, as do some health insurance plans available through large employers, inpatient and ambulatory hospital and physician care, laboratory services, X-rays, other ancillary services (such as physical therapy), prescription drugs, short-term home health services and nursing home care, vision care services, and mental health services? Should it also include, as some employers do, dental insurance? Should it cover, as almost no health insurance plans now do, long-term care at home and in nursing homes?

Employer-provided group health plans generally provide the most comprehensive benefits available with private insurance. Most indi-

vidually purchased insurance plans provide very limited benefits. Medicare provides a moderate range of benefits. Some state Medicaid programs provide a very narrow range of benefits, while others offer a very broad range of services.

A comprehensive scope of benefits has at least two advantages. First, a broad scope of benefits is more likely to meet the health needs of lower-income people. If services are needed but not covered by a program, they will tend to be distributed according to ability to pay, not according to need. The narrower the range of benefits included in a program, the more care will be received by upper-income persons and the less care obtained by low-income people, despite the overwhelming evidence that poor people are in poorer health. Thus, to a considerable extent, broader benefits contribute to more equitable distribution of health services.

Second, a full range of covered services allows more appropriate and less expensive services to be provided to patients. For example, nursing home care can sometimes be substituted for hospitalization, and home health services can often replace admission to a nursing home. These substitutions may be not only less expensive; they also may be more compatible with the patient's social and emotional well being. Thus, a broad scope of benefits may allow more efficient use of resources.

In the absence of financing reforms, however, comprehensive benefits would not by themselves be more efficient and, beyond some modest savings attributable to efficiencies, they would increase total program costs. These costs would be directly associated with the program and thus would carry a high political profile, whereas a similar sum spent out of pocket by individuals or employers would have less visibility as a political issue. To the extent that broad benefits have broad political support, such a program may successfully resist efforts to trim the program scope. But such benefits would generate greater support *after* they have been received by the populace, while program budgets would be likely to draw fire even in the planning stages.

*NHP Proposals.* As with coverage of the population, the Roybal and Dellums bills would provide the most comprehensive benefits. The Kennedy-Waxman bill would cover most essential health services (including inpatient and outpatient hospital and physician services, diagnostic and screening tests, prenatal care and well-baby care up



FIG. 2. Comprehensiveness of benefits in bills

to one year of age, and limited mental health services), but would not mandate truly comprehensive care (e.g., it does not include prescription drugs, vision care, short-term or long-term skilled nursing facility or home health services) and would prohibit states from requiring broader benefits. The Chafee bill would put a solid floor under state Medicaid programs, providing comprehensive benefits to the broadened group of eligible persons.

## Economic Resources for Health Care

It takes many types of resources—financial, human, and technological—to produce and deliver health care to the population. In this section, I will be concerned only with economic resources: how we might raise the revenues necessary to finance the production and delivery of health care, and how we might allocate those economic resources within the health system.

### *Financing: Equity and Politics*

How will funds be raised to pay for a national health care program? With total national health expenditures now above 11 percent of the gross national product (GNP) and expenditures for personal health care reaching 9.6 percent of the GNP in 1986, the methods by which revenues are generated would have a major impact on the economy, on the distribution of income, and on the distribution of health services. Financing methods thus have important implications for equity—including both income policies and access to care—and for political support.

The most regressive, inequitable way to finance health care is out

of pocket, forcing people to pay all the costs of care at the time they need it. This financing method results in an extreme form of price rationing, distributing care to people primarily according to their ability to pay for it, rather than mainly according to need. Private health insurance grew in popularity because it spread the financial risks of medical care among a large group of people and thereby reduced the individual financial impact of costly illnesses and injuries. It brought increasingly expensive hospital and physician services within reach of the working population and avoided the financial hardships that accompanied costly medical care even for the middle class. Thus, private health insurance is more equitable than the absence of any insurance program, promoting not only more equal use of services but also more progressive financial contributions to pay for health care services.

Private health insurance itself, however, is regressively financed by premiums: a flat amount charged per enrollee regardless of income. The regressiveness of premiums has been mitigated because they have been paid mainly by employers of higher-paid employees and thus represent a relatively low percentage of payroll—on average, about 6 percent (U.S. Chamber of Commerce 1987). The flat dollar amount of premiums is very regressive, however, for individuals and families who need to buy their own insurance.

The enactment of Medicare and Medicaid in 1965 was intended to address the problem created by the price rationing of private health insurance, extending care to the elderly and welfare recipients who could not afford private insurance premiums (Brown 1983). Compared to Medicare, Medicaid is more progressively financed because its costs are met entirely by federal and state general revenues (which are generated by fairly progressive income taxes), while Medicare is financed by a combination of federal general revenues, a premium, and a flat tax on earnings and payroll (with no tax on earnings above the cap, now set at \$45,000).

*Premium- vs. Tax-Financed NHP.* One approach to national health legislation is to mandate employers to provide health insurance to their employees and their employees' dependents. The Kennedy-Waxman bill and a more recent proposal by Rep. Pete Stark (D-Calif.) rely on this strategy as does Hawaii's Prepaid Health Care Act of 1974, which has resulted in a high level of health insurance coverage of the state's population. Among all the states, Hawaii has the largest

percentage of its employees who receive health insurance as a fringe benefit (65%) and the third smallest percentage of nonelderly population who are uninsured (11%) (Brown et al. 1987). The main advantage of this tack is that it allows the Congress and state legislatures to enact social programs, like health insurance, that cover most (but not all) of the population and yet avoid the political risks of raising taxes to pay for them and having them show up in the federal budget (Rosenblatt 1988). And for two-thirds of the population, health care coverage is financed now by employer-based premiums, giving this method the advantage of familiarity and political acceptability.

But employer mandates have some drawbacks. First, they cover only the working population, leaving the economically and politically most vulnerable population outside the program. Second, because they finance programs with premiums that are not tied to ability to pay, they tend to be regressive. This is a problem for employers of low-wage employees, who disproportionately comprise the uninsured, because it would represent a much larger percentage of payroll. For example, although the Kennedy-Waxman bill probably would not raise labor costs of employers who already provide fairly comprehensive insurance to their employees, employers who pay very low wages would see their payroll costs increase by as much as 20 percent (statement of Edward M. Gramlich, Congressional Budget Office, Nov. 4, 1987). Such a program could offset the price-rationing effects of premiums by providing low-income people with subsidy. This system would, however, require means testing (at considerable administrative expense), and it would still be regressive for moderate-income groups whose political support for the program might be diminished as a result.

A national health program that is financed by tax or other contributions proportional to income would be more progressive than one financed by premiums. One tax-based option that is similar to present employment-based financing would be to collect all funds as a tax on employers' total payroll and on employees' wages, as Medicare part A is financed by a flat tax on payroll and earnings. A total tax of 8 percent on earnings (including some combination of employer and employee taxes) would yield revenues far in excess of the combined payments of employers, employees, and private individuals for health insurance premiums. Even such a flat tax would be more progressive

than premiums, however, because more money would be collected from higher-paid workers and their employers than from those with lower earnings. A tax on individual nonwage income and corporate profits would capture unearned income and help to pay for the health care of the one-third of the presently uninsured population that is not in a family with an adult wage earner.

Compared to employer-based premium-supported financing of health care, a tax-financed system would be more efficient and result in more continuity of coverage and care. With employment-based programs financed by premiums, individuals enroll in health plans through their jobs and thus may find their coverage interrupted or have to change from one plan to another when they change jobs, become unemployed, disabled, or retired, or even when they become divorced or widowed from a spouse who has provided their coverage (Enthoven 1980, 116). The changes in insurance that accompany changes in employment and the determination of eligibility for subsidies to low-wage earners would add substantial administrative costs to any program.

A tax-financed system would avoid interruptions and changes related to employment because a person's coverage would not be job related. Similarly, because individuals would not have to pay directly for their coverage, there would be no need for any eligibility determination for a subsidy. A program supported by taxes on earnings or income has a built-in ability-to-pay standard through the tax rates, rather than requiring a separate administrative procedure in the health system. Individuals receive coverage as a matter of entitlement through a social insurance system, not because they have paid a premium. Finally, the very high administrative costs of the United States health system (Himmelstein and Woolhandler 1986) might also be reduced because revenues would be raised through the regular tax collection process, rather than as a separate administrative task imposed on employers and insurers.

*Cost Sharing.* In addition to premium and/or tax payments for health care, revenues can be raised and costs can be controlled by requiring patients to pay deductibles or copayments for health services. Cost sharing is widely used in private health insurance to discourage "unnecessary" use of services and to require enrollees to pay a portion of covered benefits, as well as paying for all uncovered services, thus keeping down total expenditures in a given program. Employer-pro-

vided health plans recently have been increasing required cost sharing by employees for premiums and for medical care (Jensen, Morrisey, and Marcus 1987; Short 1988). Most individually purchased insurance plans charge substantial deductibles and copayments. Medicare has imposed deductibles and copayments both for hospital insurance and for supplemental medical insurance, although under the new catastrophic health insurance program, hospital care will require only a deductible. Since the Nixon administration, state Medicaid programs have been authorized to impose copayments on users. National health programs in many advanced capitalist countries with well-developed social welfare systems require some amount of cost sharing by patients, although it is usually waived for low-income persons.

The issue of cost sharing and its impact on use of health services and health status is a contentious one. Both proponents and opponents of cost sharing can find support for their positions in the research literature. First, cost sharing is an effective way to reduce utilization, total health care costs to the program, and total health expenditures (Davis 1975; Newhouse et al. 1981). Requiring patients to pay some of their own disposable income for medical care restrains their use of services. Second, the Rand Health Insurance Experiment found that even substantial out-of-pocket costs had a measured impact on health status only for low-income persons who were in poor health at the start of the study (Shapiro, Ware, and Sherbourne 1986; Lohr et al. 1986). This disadvantage could be reduced by exempting from cost-sharing requirements any low-income person with a chronic illness.

Cost-sharing also has serious disadvantages, however. First, cost sharing equally reduces use of services that are highly effective and those that are rarely effective (Lohr et al. 1986). As a mechanism for restraining economic demand, it shares the irrationality of many other market mechanisms. Second, paying a flat amount or a percentage of medical costs out of pocket is regressive, since such formulas ignore patients' financial status, and cost sharing thus has a disproportionate impact on the poor. This pattern has been confirmed by the Rand study which found that cost sharing had a larger impact on low-income enrollees (especially children) than on more affluent groups, despite the fact that cost sharing was income-adjusted (Lohr et al. 1986). Programs could waive copayments for the poor, but the costs of means testing add substantial administrative expense.

Third, requiring copayments for services with highly elastic demand



(e.g., physician office visits, certain outpatient procedures) provides incentives to substitute more expensive services that require no co-payment (such as substituting inpatient for outpatient care) or to postpone use of services, which may result in more expensive treatment at a later date (Roemer et al. 1975). Cost sharing under national health insurance might also encourage people to buy supplemental private health insurance, vitiating any objectives of containing total health expenditures (Conrad and Marmor 1980).

Finally, there are alternative ways of controlling utilization and costs that avoid some of the disadvantages inherent in cost sharing. Triage by nurse practitioners, primary care case management, queuing for nonurgent care, and budgetary control—widely used in HMOs and government health systems in the United States and in national health programs in other countries—are effective methods of discouraging frivolous or unnecessary care. Although these strategies impose some inconveniences and delays that many patients dislike and that require monitoring to prevent underutilization, they are in many ways preferable alternatives. These devices apply professional judgment (technical rationality) rather than controlling economic demand (market irrationality) in setting priorities for providing care. They also may be more equitable to the extent that access and use are based on need, rather than on ability to pay. Low-income enrollees in HMOs generally have not fared as well as more affluent groups. They apparently find it difficult to “work the system,” a skill that middle-income enrollees are more likely to possess, and they should be provided with outreach and orientation to the system to help them overcome bureaucratic barriers (see Luft 1981, 320–41; Ware et al. 1986).

*NHP Proposals.* The Dellums bill would obtain revenues for its trust fund from a variety of tax sources, including income, corporate, and payroll taxes. The Roybal bill would tax employers' payroll costs, continue and uncap the Medicare tax on earnings, increase the cigarette tax, charge states for up to one-half the costs of their residents under the poverty line (with a formula of state contributions based approximately on the Medicaid formula), and supplement these funds with a surcharge on corporate and personal income taxes—a combination of progressive and regressive revenues. The Roybal and Dellums bills would provide comprehensive benefits with few out-of-pocket costs for users, although the Roybal bill does impose limited cost sharing

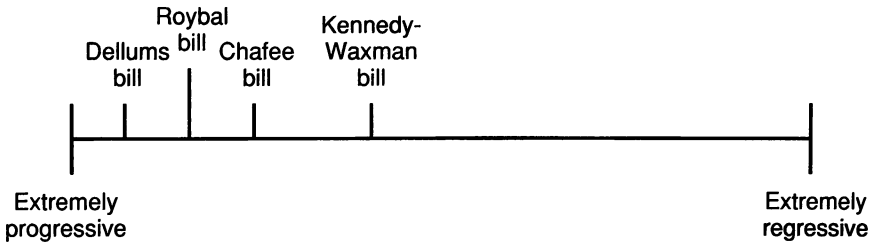


FIG. 3. Progressivity of financing in bills

for long-term care on users above the low-income level. The Chafee bill would raise funds from general tax revenues, which are relatively progressive, in much the same way Medicaid now does, dividing the costs between the states and the federal government. The Chafee proposal would also allow uninsured persons with family incomes up to 250 percent of the poverty line to buy into it on a sliding premium scale. Unlike these three bills, the Kennedy-Waxman bill would rely on employer and employee premiums to finance the care of workers and their families, with employers paying at least 80 percent of the costs (employers would pay the entire amount for very low-wage employees). Although these provisions are relatively generous to employees, the impact on low-wage-paying employers and the potential impact on employees above the lowest wage group make the Kennedy-Waxman bill's financing the least progressive of the four.

### *Efficiency of Resource Usage*

We do not need to love mammon more than health to appreciate the relevance of making efficient use of resources that have been devoted to health care. Health and medical care costs have been growing considerably faster than the general rate of inflation (as measured by the Consumer Price Index) for decades. We now spend more of our gross national product on health care than any other industrialized nation in the world.

Therefore, it is appropriate to assess how well a NHP proposal would control total health expenditures, and how appropriately it would distribute those expenditures. Would the proposed program allocate resources within the system in ways that encourage the provision and use of appropriate types of medical technologies (both

human and machine) and promote equitable access to care? Would providers be paid in ways that encourage participation and quality care but control costs? Although it is difficult to develop consensus among professional and technical experts about what constitutes efficient allocation of resources, appropriate application of technologies, and optimal volumes of usage, we may nevertheless find it useful to apply evidence of the impact of present systems of financing and organizing health services to assess the probable impact of alternative NHP strategies. ("Efficiency," which usually describes the amount of output per unit cost, refers here to the total resources used to provide health care to a defined population served by a delivery system. In this sense, it refers to systemic efficiency and is related to control of total health care costs.)

*Alternative Ways to Pay Providers.* Reimbursements to providers, as distinguished from budgetary allocations, have been the major way we pay for health care in the United States. Reimbursement of costs or fees pays for capital, labor, other operating expenses, costs of teaching (for teaching hospitals), and profit. Physicians have been granted a technical and economic role as agents for their patients based on the special role of medicine in dealing with life and death issues, the expertise required to make medical judgments, the service commitment proclaimed by the medical profession, and the political power to protect this relationship (Evans 1984, 69–91). Providers acting as agents for the patient and, to a lesser extent, users themselves generate economic demand for health services. Under cost-based and fee-for-service reimbursement, this demand drives total health care costs for any payer and for the society as a whole. Most reimbursement methods have proved inflationary, as hospitals, physicians, and other providers have found innovative ways to generate more revenues from an essentially open-ended financing system. For example, when Congress imposed prospectively determined payments for care of Medicare beneficiaries in hospitals, physicians and hospitals shifted significant portions of care out of the hospital, slowing program costs of inpatient care but escalating expenditures on outpatient services.

Systems that cap total expenditures and budget all providers of care, rather than reimbursing them for expenses they have incurred, are economically more efficient. This strategy puts both the buyer and seller of services at risk. "The buyer takes the risk that actual costs may fall below the bargained rate. The providers assume the

risk that costs may be higher" (Somers and Somers 1977). This is what HMOs do when they accept financial risks of providing care to their enrolled populations for the total of all capitation payments they receive. Many countries' national health systems provide capitation payments or operating budgets to organized delivery systems, such as regional health care authorities, hospitals, and clinics.

Any system that sets some limits on the amount of resources that will be spent within the system or in any unit of the system requires rationing. The issue is not *whether* to ration, but *how* to ration. Rationing occurs now in a variety of ways, including price rationing (allocating care according to the ability to pay for it) imposed on users, although this is mitigated to the extent that users are protected by insurance or subsidy from paying out-of-pocket costs. Rationing is also imposed on users by third-party payers when they require copayments and deductibles, exclude certain services or conditions from coverage, require second opinions before surgery, or require case management by a primary care physician. When rationing is imposed on users, the individual patient and the patient's family must decide whether to spend money or time obtaining health care instead of spending it some other way, assuming they have the resources to make such a choice (Brown 1987).

*Paying Professional Providers.* The allocation of resources to providers critically affects how economic resources devoted to health care are used to provide care. Every provider, and especially every professional, desires autonomy in her or his work. Physicians argue that autonomy is essential to providing competent, quality medical care in the patient's interest. One method of rationing that leaves considerable autonomy in the hands of professionals is to set only the budget limits within which institutions and individual providers must work. This approach lets each institution or provider decide how best to allocate available resources. Capitation payment systems for physicians' services exemplify this budgeting method, in which physicians operate within budgetary constraints and merge technical judgments and social values in allocating their time and resources. David Mechanic (1978, 1985) calls approaches like this "implicit" rationing because these methods "do not specify what services should be provided or what assessments physicians should make, but achieve their effects by placing greater pressures on doctors to make hard allocation choices."

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In national health services, physicians and other professional providers are generally salaried employees of the institution or system, although in the United Kingdom most general practitioners remain in private practice and receive capitation payments and some fees for persons enrolled with them. Many national health insurance programs pay independent practitioners fees for each service, but unlike the United States these fees are based on a fee schedule negotiated by the health authority with the provider's professional association. Such negotiations are common in Canadian provincial health insurance programs and in other countries, as well as in some types of HMOs and other contract arrangements in the United States (Somers and Somers 1977). Any of these systems are economically more efficient than the virtually unique method that predominates in the United States—namely, reimbursing providers essentially whatever they charge, often in some combination of payments by a third party and out-of-pocket payments by the patient.

What makes these alternative systems economically more efficient is that they provide less incentive for providers to waste resources. That is, they reduce the likelihood that providers will use more resources in caring for a patient than are justified by the physical, emotional, and social needs of the patient and the potential benefit that may result from the medical intervention.

The specific content of medical practice can be influenced to give greater emphasis to evaluation-and-management services compared to invasive technological procedures by changing the basis of fees, as the proposed resource-based relative-value scale seeks to do (Hsiao et al. 1988). Even fee-for-service reimbursement systems can control total costs if they both use a fee schedule and monitor and limit the volume of services billed by physicians and other professional providers (Barer, Evans, and Labelle 1988).

Capitation payment, of course, discourages excessive use of resources. Once the provider has been paid for some unspecified amount of care to be given to a patient, then the provider has incentives to underserve enrollees (the opposite of fee-for-service incentives that encourage providers to do more for their patients). Care given to a patient represents the use of limited resources available to the provider, either taking resources away from some other patient (e.g., increasing the length of the queue for services) or adding to the provider's cost if more resources (e.g., another doctor or a nurse practitioner) were

hired. These tendencies are restrained by professional providers' socialization and motivation to render competent care and by keeping professional providers at a distance from financial incentives (e.g., not allowing them to realize a direct financial gain by not ordering a service for a patient) (Hillman 1987). Physicians' "agency" role creates a conflict of interest when physicians may benefit financially from ordering, or not ordering, procedures for their patients. Regulatory agencies, such as peer review organizations (PROs), could also use mandatory information systems and regulatory powers to identify and correct these tendencies toward underservice. Enabling enrollees to choose an alternative source of care if they are dissatisfied with their present source provides an additional restraint when the providers' revenues or budgets depend on attracting and keeping patients.

*Paying Hospitals.* The method of paying hospitals raises many of the same issues—except that the stakes are even higher. Hospitals consume about 40 cents out of every \$1 in total health expenditures, compared to 20 cents spent on physicians services (*Health Care Financing Review* 1987). Cost and charge reimbursement, the traditional methods used by private insurers, Medicare, and Medicaid to reimburse hospitals, proved so inflationary that in recent years public and private third-party payers have scrambled to find cost-restraining alternatives. Hospitals were required by Medicare to obtain a certificate of need from their state agency in order to be reimbursed for new capital costs. Utilization review committees and (under Medicare) peer review organizations were mandated to assess the need of patients for continuing hospitalization. Some states established rate-setting commissions to regulate the reimbursement rates paid to hospitals by third parties. Some Medicaid programs and private insurers (operating preferred provider organizations, or PPOs, and HMOs) have contracted with hospitals to obtain discount rates for their enrollees. All of these cost-containment methods attempt to reduce unnecessary costs within essentially open-ended reimbursement systems.

Other, and generally more effective, payment systems do not retroactively reimburse hospitals for their costs. For example, in 1983 Medicare replaced retroactive payment of costs for the hospitalization of Medicare patients with a prospectively set lump sum payment for each episode of hospitalization, with the amount determined mainly by the Medicare patient's diagnosis-related group (DRG) and not by how many services and hospital resources were provided.

Another strategy pays hospitals using prospective global budgeting, in which each hospital receives an annual budget within which it must operate and provide necessary services. In Canada, hospitals negotiate their budgets with the provincial health insurance agency to cover all necessary capital and operating expenses. The Kaiser Health Plan system's own hospitals, Veterans Administration hospitals, military hospitals, and most public hospitals in the United States also operate within annual budgets.

Prospectively-set reimbursement per hospitalization appears to be more effective at restraining costs than are cost-containment methods imposed on retrospective reimbursement for costs and charges. Prospective global budgeting is probably more effective still at controlling hospital expenses. Both DRG-type payments per hospitalization and prospective global budgeting require hospital administrators and professionals to allocate their resources where they believe they will be most effective. Neither strategy aimed at hospitals, however, is likely to increase overall efficiency in the health system if other types of care, especially physicians' services are not included in a similar financing system. Indeed, it is likely that the broader the range of services included in a single financing and payment system, the greater the opportunities for efficiently organizing and producing health care for the covered population.

*Paying Health Plans.* An alternative payment system, a variation on present HMO arrangements, would have the national health program make capitation payments to health plans which would be free either to hire physicians and other professionals and/or operate their own hospitals or to contract with professional providers and with hospitals. This seems to be the direction in which third-party relations with enrollees and providers are moving: health plans obtaining discounted rates from hospitals and professional providers and restricting enrollees' sources of care to contract providers. Under this arrangement, all health plans would be held at financial risk for providing specified care within the total revenues they receive. This approach has obvious cost-containment advantages demonstrated by HMOs, including imposing financial incentives on health plans to reduce unnecessary use of hospitalization and expensive procedures, and potentially reducing administrative costs by simplifying billing and reimbursement systems. But any capitation payment system also would have potential problems associated with HMOs, including

financial incentives for providing too little care, bureaucratic and/or financial constraints that discourage provider participation, and incentives to market primarily to low-utilizing populations.

Just as with HMOs, monitoring and regulation would be required to assure quality of care and to prevent underutilization. In addition, if enrollment is not tied to employment and enrollees are able to change to other health plans during open enrollment periods, competition could be a useful adjunct to improve responsiveness of health plans to their members. Provider participation would be less problematic than it is today if all providers' incomes depended on affiliation with one or more plans. Associations and unions of health professionals should be encouraged to negotiate fees and other contractual arrangements with health plans, as medical societies do in Canada and some other countries, and as large group practices and some medical societies do in the United States.

Finally, if a system were to provide uniform capitation fees for all enrollees, health plans would have incentives to market only to relatively healthy, low-cost populations. This tendency could be mitigated by regulating and closely monitoring marketing practices, an uphill struggle against the incentives of the market. Or it could be avoided by paying risk-adjusted capitation fees—which involves classifying the population into a number of risk groups, based mainly on age and sex, and paying capitation fees that reflect the average actuarially determined costs of caring for persons in each risk group in a wide geographic area. This risk-adjusted capitation payment would eliminate the incentives for selective marketing. Although it sounds similar to experience-rated insurance premiums, paying providers on the basis of actuarial risk would not have inequitable consequences for insurance coverage if individuals' payments into the system were income-based (as in a tax-financed system) or even equal (as with financing by community-rated premiums).

In ranking payments on the basis of the economic efficiency of the total system, budgeting facilities and salaries for personnel might be rated most efficient, followed by capitation to organized health plans and individual professional providers, then negotiated fee schedules and contract rates, and finally unrestricted reimbursement of charges and costs. Each of these methods requires vigilant monitoring to assure that patients' needs are being adequately met—monitoring cost- and fee-reimbursement methods for excessive care (which is both inefficient



and potentially dangerous to health status) and monitoring capitated, salaried, and budgeted systems for underservice (which would reduce the effectiveness of health care in improving health status). It should be emphasized that efficiency is only *one* criterion by which health programs and systems should be judged, and it is *not* more important than equity or other principles.

*NHP Proposals.* The Dellums NHS proposal would budget all units within the government-run health system and pay all providers by salary, a radical departure from present arrangements. The Roybal NHI bill would pay professional providers according to a fixed fee schedule and hospitals according to Medicare's DRG system, and it would pay HMOs a capitation payment according to a formula that is more generous than the one Medicare now uses. Both of these proposals attempt to control total costs: the Roybal bill by capping total health expenditures at 12 percent of the gross national product (although enforcement of the cap is not clear), and the Dellums bill by annual budgeting. Both bills also organize substantial control over allocations within the system: the Dellums bill through its national to local budgeting process, and the Roybal bill by encouraging the growth of health plans that would operate at financial risk within budgets created by the sum of their capitation payments. The Chafee bill would continue present methods of payment by Medicaid programs although it might encourage more states to contract with prepaid health plans. The Kennedy-Waxman proposal would facilitate the availability of HMOs, but it would not otherwise significantly affect the way private insurers pay their bills. The probable impact of each bill on efficiency of total resource usage is schematically described in figure 4.

### *Planning and Market Allocation of Resources*

Planning makes use of rational, technical methods to allocate resources according to program objectives. It can be distinguished from market allocation of resources which is arational from a societal perspective, relying on many interactions between buyers and sellers (which may be rational from their perspective). Planning can be used to allocate resources on the basis of need, whereas market methods tend to allocate resources on the basis of economic demand, which depends on the

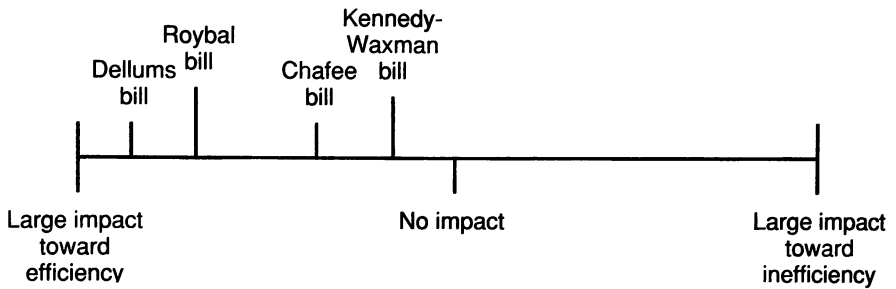


FIG. 4. Impact on efficiency of resource usage by proposed programs

ability to pay for goods and services. Planning gives a great deal of influence to technical and professional planners (pejoratively known as "bureaucrats"), while the marketplace gives more autonomy to individual sellers and sometimes to buyers (in health care parlance, "providers" and "consumers"). The distinction between planning and market allocation of resources is an important one in analyzing national health programs.

Planning permits a more efficient allocation of resources to meet technically defined community health needs, but it often provides a narrower range of choices than users prefer and for different needs than they might identify. On the other hand, market methods may meet consumer desires (as distinguished from technically determined needs) more effectively than planning—if the marketplace promotes competition among providers for dollars controlled by consumers, if consumers all have enough dollars (either out of pocket or paid by someone else) to participate, and if consumers are well informed and able to discriminate accurately among alternatives in the marketplace. Of course, sellers usually plan what they will provide on the basis of the potential profit from, and predicted economic demand for, possible products, and they shape demand by marketing and advertising. The marketplace thus gives providers more autonomy to decide what services to provide and to whom than does a planned system. This autonomy gives providers considerable power to meet consumer desires, but it also allows them to shape health care delivery in ways that differ from what is necessary to meet technically and professionally determined needs and assessments of types of care that would be technologically and economically most appropriate. In a market system, economic demand and profitability substitute for health needs

as determinants of what will be produced, and health services become commodities.

Planning can be made more responsive by decentralizing much of it and involving affected communities in the planning and decision-making process. Publicly owned health care insurance and delivery systems could include competition among health care providers or organizations to make their systems more responsive to users' needs and desires. Market systems also can be modified through regulations and incentives to approximate the resource allocation strengths of planning. Government can influence the market by requiring permits for capital investment and construction (for example, certificate-of-need laws), regulating the prices of goods and services sold in the health care marketplace (as hospital rate-setting commissions do), or providing financial incentives to influence institutional or individual provider decisions, but these methods are only indirect and often burdensome.

Thus, a national health program that relies entirely on planning to allocate resources and to provide for all health needs will tend toward bureaucratic unresponsiveness. On the other hand, any system that relies primarily on the marketplace to allocate resources will be shaped by providers and other corporate institutions to meet their needs, using societal resources efficiently and meeting the population's health needs *only* to the extent that such practices are consistent with the interests of the dominant players in the market.

A NHP could rationalize the allocation process by using central and regional planning of system resources, but remain responsive to consumers' own definition of their needs and desires, by facilitating their participation in local health planning structures that actually control some purse strings and by allowing market competition among organized health care delivery systems. For example, a central financing agency could directly allocate capital and operating budgets to regional tertiary care institutions, but it could grant to local planning councils that demonstrate adequate community and consumer participation the decision-making authority, for example, to approve or allocate capital to local providers. A central financing authority could also provide vouchers to consumers that would enable them to enroll in the health plan of their choice, selecting among competing plans in their area, with the financing agency paying a capitation fee to the health plan for each person enrolled. This model might facilitate

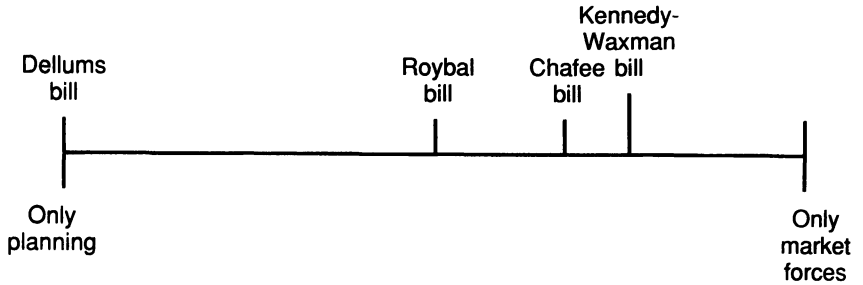


FIG. 5. Use of market and planning to allocate resources

striking a balance between the technical rationality of central and regional planning, professional autonomy of providers who would make allocation decisions within the budgetary limits of their capitation revenues, and responsiveness to consumers through their admittedly limited market power to take their vouchers (and thus their money) to a competing health plan.

*NHP Proposals.* The Dellums bill would entirely exclude market forces from its national health service; it would replace the market with bureaucratic planning methods, although it would inject a great deal of user (and some professional) control through locally elected governing boards. The Roybal bill would provide a mix of bureaucratic planning in the allocation of total resources, but it would allow a very large role for the marketplace to meet user demands, while regulating the markets and providers' marketing behavior. The Kennedy-Waxman bill would rely entirely on market forces in the allocation of resources, although it would regulate the costs and marketing of health plans. The Chafee proposals also would use market forces although it implicitly would give considerable power to state Medicaid programs as very large volume buyers of services.

The Roybal bill thus represents the most integration of planning and market forces. Planning would govern policies concerning persons covered and benefits provided, financing and budgetary control, and capital allocation, while the marketplace would be permitted to create competition among different plans to attract and retain enrollees, responding to their desires within the boundaries set by planning. Figure 5 graphically describes the use of planning vs. market forces as the main methods of allocating economic resources in each bill.

## Accountability of Health Services

Providers of health services may be considered accountable when those who use them and those who pay the bills can hold them responsible for meeting their objectives or needs. Without entering into admittedly difficult conceptual and operational discussions of satisfaction and quality of care, we may assume that in every system of providing care users and payers should be able to have some leverage to satisfy their legitimate concerns.

One way to assure user satisfaction is to rely on market alternatives. Users may be more satisfied in situations where providers are financially dependent on users remaining with the provider and where users can "take their business elsewhere" if they are dissatisfied. This consumer choice requires real alternatives that are about equivalent in cost and other indicators of access. Before the days of organized health plans, this was the traditional method by which patients could hold their doctors accountable. Increasingly during the 1960s and 1970s, dissatisfied well-insured moderate- and upper-income families had some market alternatives which enabled them to seek more satisfactory alternatives, but low-income families, including those on Medicaid and the uninsured, generally have had to take what they could get. During the 1980s, however, it is likely that even the relatively well-insured working population has been losing some of its market power, as insurance options have become more complex and less comparable, and as employers increasingly have imposed cost sharing for premiums and services that make it more expensive for employees to choose some plans than others (Jensen, Morrisey, and Marcus 1987; Short 1987). Furthermore, at its best this market approach to consumer satisfaction gives the provider a great deal of autonomy, and is not the only, or most effective, way to promote accountability. In fact, it tends to remove dissatisfied people from a health care setting or plan, as though the dissatisfaction is their problem, and does not require any changes from the provider or plan unless their business is really hurting.

Other methods involve systems of accountability, including requiring health plans and facilities to provide uniform data on utilization, finances, and other indicators of service with enough detail so that reasonable assessments can be made of their programs (see Enthoven 1980, 81–82, 129–30). In states and national health systems

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that regulate providers, these information systems provide an important basis for assessing compliance with government-set standards. In recent years, large employers have begun to evaluate how effectively health plans and some providers meet their needs. But these state and federal programs and employers have shown much greater concern with controlling their own costs than with other issues that concern users of health services.

All of these methods rely on regulations to control the market, in a sense to increase the influence of consumers and/or payers relative to providers. An alternative approach would create structures in which users could play a direct role in governance or policy making. The Dellums bill, for example, would enable users and workers in each local health center to elect boards that actually govern their center, with local boards electing representatives to district, regional, and national governing bodies. Such structural changes give nominal authority to users, but they are very imperfect methods for giving them actual power. Experience suggests that it is difficult to organize and sustain effective consumer representation (Marmor and Morone 1980; Checkoway 1982).

Nevertheless, as the preceding discussion about allocating resources suggests, accountability too may be improved by an integration of multiple approaches. These might include requiring individual health plans to be approved by the NHP agency in order to receive payments under the program, having the NHP agency determine whether health plans meet usual requirements related to quality assurance and financial viability, and imposing reporting requirements to provide relevant information to governmental agencies and consumers to enable them to make appropriate judgements. In addition, accountability to users can be facilitated by establishing formal processes for consumer and community involvement in accrediting health plans to participate in the NHP as well as by market mechanisms, such as vouchers that would assure access to competing health plans.

Cooperatively owned health plans also would increase accountability, at least to the groups who form and actively participate in them. For example, consumer groups and communities could form their own health plans that would give their representatives an increased role in policy and decision making. Professional associations, such as local medical societies or independent medical groups, could also form health plans, receiving capitation payments for enrollees and arranging

payment provisions to member physicians and other providers on whatever basis they find most appealing within the financial constraints of aggregate premiums. Such cooperative models, including some health plans, have a long and successful history in the United States.

The issue of accountability raises questions about the role of for-profit chain ownership of hospitals, nursing homes, HMOs, and other health services in any NHP. Chain ownership removes accountability not only from the users of services; it also tends to remove professionals and community-based elites from policy making. Compared to decisions made by users or local professionals and community leaders, decisions made in distant board rooms will be less likely to reflect community health needs, except those needs that are profitable to fulfill. Therefore, it may be warranted to analyze ways in which NHP proposals might encourage local accountability of for-profit chain ownership or restrict ownership to not-for-profit and public entities. For example, imposing accountability structures and procedures, price regulation, and other regulation (including regulating rates of profit) may facilitate corporate responsibility by all providers and might drive out less responsible ones.

*NHP Proposals.* In the Dellums bill, accountability would rest on user participation in a representative structure for decision making, which by itself is problematic, and would exclude alternative market options for users. The Roybal, Kennedy-Waxman, and Chafee proposals all rely heavily on the marketplace to assure user satisfaction, which also is problematic, even with some added provisions in two of the bills. The Roybal bill includes beefed-up PROs to monitor the quality of health care provided, not just to search for overutilization which has been their primary function in the Medicare program. The Kennedy-Waxman bill gives the secretary of the Department of Health and Human Services authority to approve or disapprove health plans based on experience with them, but does not further increase their accountability. The Chafee bill also does not address the issues of quality or accountability; since the Medicaid program would remain targeted to low-income people (albeit a much broader group than at present) with no place else to go, little improvement in quality could be expected. The Dellums bill's NHS would exclude for-profit health care from the system. The Roybal, Kennedy-Waxman, and Chafee bills do not address the issue of for-profit health care although recent experience with for-profit health plans would suggest that the Roybal

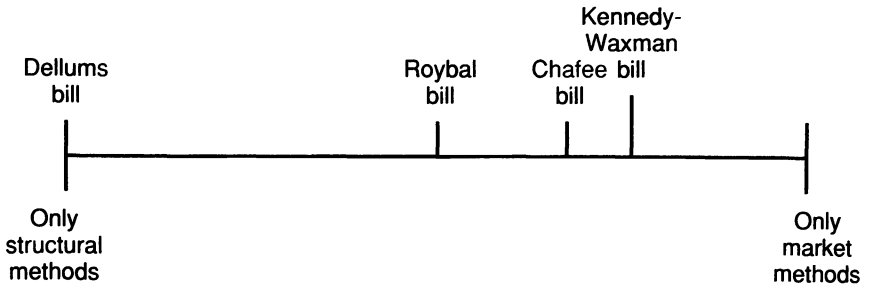


FIG. 6. Forms of accountability in each proposal

bill's explicit encouragement of HMOs and their strong regulation might create some disincentives for for-profit corporations. Figure 6 depicts the relative importance of structural vs. market methods of accountability in each proposal.

### Political Feasibility

Broadly speaking, we may identify three perspectives on national health insurance, corresponding to the alignment of political forces around issues of health care reform (Alford 1975). Proponents of one school of thought, what Robert Alford called the "bureaucratic or planning perspective," have waged a battle for national health insurance since at least the 1940s. Exemplified by efforts to enact the Wagner-Murray-Dingell and Truman bills in the 1940s and the Kennedy-Corman bill in the 1970s, leaders of these struggles have been visionaries of a public health model of medical care, one that conceives of a publicly planned and rationally organized private and public system of delivering care to the entire population. Their bills carefully defined the substance and often the details of the NHP they believed would be virtually ideal.

Opposing these advocates of national health insurance are "market reformers" who favor letting the private market distribute health services. Over the years, they have come to support government intervention, but only to pay for persons who cannot afford the costs of their own care. Representing the dominant private-sector interests in health care, the market reformers have generated the most political power over time, particularly when they have won support from other



powerful interest groups and classes. They successfully fought off political supporters of national health insurance in the 1940s, in good part by evoking fears of government health insurance leading America down the path toward socialism (Fein 1986). And they led the effort to reduce public-sector health planning and to rely on competition among providers to control costs.

The third group joined this debate most prominently during the 1970s. This group's perspective, shaped by the civil rights and antiwar movements of the period, views problems of access and costs in health care as reflecting broader institutional and structural characteristics of American society. They argue for major transformation of the organization and control of health care in the United States, and they focused their efforts on enacting the Dellums bill as a model of the national health service they favored. Espousing an "institutional or class perspective" (Alford 1975), they often directed critical attacks at advocates of national health insurance as much as at advocates of market reforms, arguing that both promoted private ownership and control of health care. Although many NHS advocates acknowledged the improbability of success within the foreseeable future, they continued to support the Dellums bill as a model that might stimulate political discourse (Rodberg 1987).

But times have changed and are changing still. The political battles for a NHP, from the 1940s through the 1970s, have led many advocates to give added consideration to political feasibility (that is, the prospects for a proposal to be enacted) in setting legislative goals. Many have concluded that they do not have sufficient political muscle to enact a model program and have given their support to proposals they find far less than ideal.

During the late 1950s and early 1960s, for example, proponents of national health insurance readjusted their legislative objectives downward to a social insurance program to cover health care costs for the elderly. They succeeded in enacting Medicare and Medicaid in 1965 as a fallback position from their failed earlier goals (Brown 1983; Marmor 1973; Fein 1986, 33–68). With the dominance of market reformers from the late 1970s through the Reagan years, advocates of national health insurance have preoccupied themselves with winning very modest incremental reforms, usually amounting to expansion of public programs by adding new benefits or making additional groups eligible.

Advocates of a national health service have increasingly abandoned the Dellums bill as the focus of their efforts, recognizing their own political weakness, the political isolation that was added by their opposition to less far-reaching reforms, and the value of intermediate reforms. And very recently, political support for purely market-oriented reforms has been weakened by two persistent problems: the complete failure of competitive strategies to stem rising health care costs, and the increasingly visible problems of restricted access and uncompensated hospital costs resulting from the growing numbers of uninsured. Recognition of these problems represents the limits of political consensus to this point but, with each of the major health care political camps adopting a more pragmatic perspective on reform, realignments are possible and the prospects of enacting a national health program would appear to be improved.

If these enhanced prospects are to be realized, advocates must give appropriate consideration to a proposal's political feasibility. But should political considerations take precedence over substantive elements of a national health program? Are issues such as population coverage, benefits provided, financing, payment for services, allocation of resources, and accountability less important than feasibility? The choice is seldom clear, in large part because it is difficult to weigh the small benefits of an option that seems immediately realizable (say, within a two-year legislative cycle) against the potentially greater benefits of an alternative that is distant at best.

Is it preferable to support incremental reforms that provide modest benefits now, or hold out for more desired changes? Advocates of incremental legislative victories reasonably argue that such changes meet important immediate health needs of many groups. They also argue that incremental reforms advance the cause of more far-reaching reforms by further legitimizing demands for government health programs and by creating an ever broader constituency of support. Incremental reforms, however, may be equally likely to undermine efforts to achieve broader and deeper change in health care. By meeting significant health needs of groups with political appeal or power, such reforms may reduce political support for more fundamental change, leaving important needs of less-powerful groups unmet and leaving some important problems of the present system unchanged. The Kennedy-Waxman bill's employer mandates, for example, would cover employees who work at least half time, and their dependents

(about two-thirds of the uninsured). But would that in turn sap the strongest political base for enacting a universal program also covering the self-employed and those not in the labor force (or even a collection of programs that would cover all the uninsured, as in Massachusetts)? In many respects, the decision rests on judgments about the political prospects of each alternative proposal.

Nevertheless, several factors make it difficult to evaluate the political prospects of a particular proposal. First, political feasibility of any proposal will depend on the importance attached to health care issues in the political arena. For example, even when large numbers of people have difficulty obtaining access to health care, the issue is more likely to receive attention and be considered "important" if it has been taken up by organized political groups, the media, or political leaders than if no one is promoting it as an issue. Similarly, whether the costs of health care are considered a problem depends not only on whether they are rising or falling, but also on who is paying the costs and how much they publicly complain about them. Health care and other problems may be experienced personally by individuals and groups, but they do not become political issues until groups with access to media and other political resources make them visible (Bachrach and Baratz 1962). That means that well-organized and powerful groups are better able to give visibility and political importance to issues with which they are concerned.

Second, the relative importance of various issues changes over time, sometimes within a very short period. For example, until Secretary of Health and Human Services Otis Bowen proposed that a catastrophic health insurance program be added to Medicare, most political observers believed that the chances of significant expansion of health care entitlement programs would have to await a new federal administration. Within a few months, as Secretary Bowen pushed his proposal through the White House and into Congress, he breathed new life into the political prospects for program expansion and, together with Congressional leaders, pushed this reform through to a successful conclusion. It is difficult to predict what new developments may suddenly or slowly change political conditions to make what seemed impossible yesterday appear imminent tomorrow. These new developments may include a sudden change in conditions of access or health insurance coverage among the population, new evidence regarding the extent or seriousness of access problems, an incident that dramatizes

a problem that has not yet reached "issue" status, or, as Secretary Bowen demonstrated, a change in leadership that pushes an issue to the forefront.

One scenario that seems increasingly probable is that important business groups will be impelled by at least three pressures to try to abandon their role as insurance brokers for employees and to become leading advocates of national health insurance. First, employers have faced increases in their health insurance costs of 20 percent and more each year. "We have tried a lot of things—utilization review, case management, cost sharing with employees, health maintenance organizations, preferred provider organizations, hospices—and costs are still going up 20 to 30 to 40 percent," bemoaned the president of the California Council of Employer Health Care Coalitions (Holzman 1989). There is every indication that health insurance premiums will continue their double-digit upward spiral (Mullen 1988). Increasingly complex health benefits are likely to add new administrative costs, and government regulation may also add new costs.

Second, the decision by the Financial Accounting Standards Board (FASB) that employers must show on their books all unfunded liabilities for retiree health benefits is likely to put even greater pressure on those corporations that have been relatively generous with health benefits. The national bill for these unfunded retiree health benefits has been estimated at between \$169 billion (Chollet 1988) and \$425 billion (Abramowitz 1988) or more. Accounting for such an enormous liability would certainly have an adverse impact on corporate profits and access to capital.

The third force on business is that labor/management conflicts over health benefits are likely to increase as employers (1) respond to the FASB ruling by cutting back on retiree benefits and (2) try to control health benefit costs by forcing more of their employees into HMOs and other restrictive health plans and by shifting more of their costs to their employees, making them pay more for premiums as well as much higher deductibles and co-payments. The result of these three pressures is likely to push large employers and business coalitions to seek a way out of their historic role of arranging and paying for health insurance for their employees. And about the only way out is national health insurance. In spite of their ideological reluctance to see traditionally private economic activities replaced with government-run enterprises, business leaders are unlikely, in the end, to let ideology

override their financial interests. If powerful business organizations and interests begin to lend their active support to national health insurance, what seems unattainable today may become the political certainty at that time, with constituencies and organizations contending over the issue of what type of national health insurance program should be enacted, rather than whether to enact one. This scenario is likely to be played out within the next few years.

Finally, deliberate political action may increase the political feasibility of a proposal. People who are concerned about an issue may organize and lobby on behalf of their cause and may succeed where previous efforts failed. Medicare and Medicaid, for example, were passed as a result of intensive organizing and lobbying by a growing coalition of senior citizen groups, organized labor, and civil rights organizations, together with some changes in the Johnson administration and the Congress. As political formations and social conditions change, the impact of organization and lobbying may increase or decrease. Thus, groups may increase the political feasibility of a particular proposal by their own efforts, especially if the issue is not highly polarized, if they coalesce with other groups, or if they diffuse some of the polarization by winning over, coopting, or neutralizing opponents.

National health insurance has remained the goal of some labor unions, civil rights and women's organizations, some senior citizen organizations, and health activists—a diverse but not sufficiently powerful social movement. If advocates of national health insurance are able to form broader and more powerful coalitions—say, including significant employer groups—around proposals that reflect their central principles, they are more likely to achieve political success. But they also are likely to be upstaged by such powerful groups whose interests and concerns differ from the traditional national health insurance constituency.

*NHP Proposals.* Immediate political feasibility of these four bills is probably related to the amount of change they would impose on the health care system, and especially to their perceived positive and negative impacts on more powerful and better organized health care political constituencies. For example, the Dellums national health service bill would attack the perceived interests of every organized medical industry group and the insurance industry. It would likely be attacked as “socialistic”—the thrust of the campaigns against na-

tional health insurance during the 1940s—evoking fears and opposition from conservative business interests. It also is not clear that most Americans would favor getting their care from a publicly owned and operated health care delivery system. Opponents would certainly pejoratively compare a proposed NHS with the postal system, everyone's favorite example of an inefficient and unresponsive government bureaucracy.

In contrast to the Dellums bill, Roybal's proposed NHI poses less fundamental challenges to the present health care system—i.e., uses financing methods that are closer to the present system than the Dellums bill, adopts with slight adaptations the present health care delivery system, and dramatically challenges “only” the insurance industry. It seeks to displace this powerful industry with a familiar institution by expanding Medicare to become a universal monopoly, but this aspect would appeal mainly to senior citizens, an active but insufficiently powerful constituency.

The Kennedy-Waxman bill is more pragmatic still because it expands the employer-based financing system with which people are familiar, puts a modestly comprehensive floor under health plan benefits, and involves few other changes that might threaten the insurance industry, the medical profession, and hospital industry, or other health-sector interest groups. The employer-mandate strategy is vehemently opposed, however, by powerful business groups, such as the Chamber of Commerce. It is unlikely that the coalition of consumer groups and some health industry associations that support this approach can overcome the powerhouse arrayed against it.

The Chafee bill does not challenge the interests of employers or the medical and insurance industries, but it does expand Medicaid eligibility to make this welfare program available to a substantially greater portion of the population. In the process it would increase federal and state spending and challenge deeply entrenched views in American society about limiting welfare to the “deserving” poor (Stevens and Stevens 1974). Nevertheless, to the extent that eligible groups can be portrayed as “paying their own way” into Medicaid by paying premiums on a sliding scale, it might overcome this stigma and win broader support. The Chafee bill may also receive a boost from the fact that Medicaid expansion and buy-in was George Bush's primary proposal of his Presidential campaign to deal with the country's crisis in access to health care. Keeping in mind the high rate

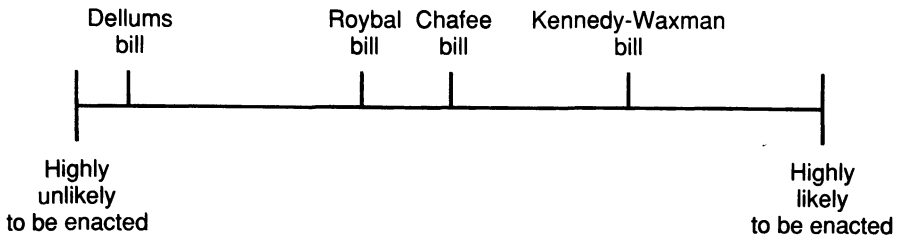


FIG. 7. Current political prospects of each bill

of error that would result from predicting future political prospects based on present political feasibility, we may compare the current political prospects for the bills along a continuum from feasible to infeasible (figure 7).

National health insurance does *not* lack public support, although the depth of that support has not been adequately explored. Recent public opinion polls have found support at the national level among about two-thirds of adult respondents (Parachini 1987; Pokorny 1988), although support has been even stronger in California (Parachini 1988) where the proportion of the population without insurance coverage is greater than the national average (Brown et al. 1987). In Orange County, California, an area that is not known for its liberal political views, 75 percent of respondents favored national health insurance, including 67 percent of Republicans (Peterson 1987). The consistent strong support for national health insurance found in public opinion polls, however, probably will not be reflected in Congressional action until its advocates are able to organize broader support among more powerful political groups or press their demands more effectively.

## Conclusion

This framework has at least two limitations. First, it does not take account of all important issues that should be considered in evaluating or developing a national health care program. For example, how human resources are allocated among professionals, among specialties, and distributed geographically is very important to access, effectiveness, and efficiency. This framework deals with this issue only within the larger issue of the allocation of economic resources and does not

devote the full attention to human resources that might be warranted. Second, the evaluations of each proposal cannot represent a simple summing up of scores from separate issue dimensions. Values assigned to each dimension and to alternative positions on each issue depend on the analyst's political philosophy and social values, as well as on technical judgment. Even the positioning of a proposal on a particular dimension according to technical criteria is very imprecise due to ambiguities in proposals and to uncertainties about the effects of elements in them. In addition, several of the issue dimensions require proposals to be ranked according to an ordinal scale, while others might lend themselves to an interval scale, further complicating any effort to quantify such an analysis. Nevertheless, a systematic analytic framework for comparison may facilitate efforts to assess the relative strengths and weaknesses of alternative strategies in advancing particular principles.

From this view it is clear that the approaches embodied in the Dellums bill to create a national health service and the Roybal bill to establish national health insurance are the only ones that would provide substantial system reform. They would institute universal population coverage in one program, permitting a large degree of equity in access and quality. Both models permit considerable systemic efficiency by controlling most health care expenditures through one payer, or a very limited number of payers. Although these bills would provide comprehensive benefits, there is nothing to prevent either NHS or NHI models from providing a narrower range of benefits, although doing so would weaken their ability to increase equity of access and to control total health care costs. The major difference is that a national health service model would rely almost exclusively on government planning and allocation of resources, whereas a national health insurance strategy would permit providers to organize services through the marketplace. The NHS system favors professional and technical definitions of need arrived at through formal planning processes (which tend to be bureaucratic, by definition), and the NHI system emphasizes provider and consumer definitions of their needs arrived at through an exchange process (which gives greater weight to providers to define needs and allocate resources).

In contrast, the Kennedy-Waxman and Chafee bills would impose far less change on the present health system. The Kennedy-Waxman bill's employer mandate would cover most workers (those who work



about half time or more) and their families, mainly affecting workers who are presently uninsured. That is not a small feat, but it would not be a universal program nor would its effect be to complete universal coverage of the population: it would leave about one-third of the uninsured still uncovered. In addition, it might actually reduce the benefit packages of well-insured workers; by mandating less than very comprehensive benefits and prohibiting states from imposing more stringent requirements, it may lead to narrower benefit packages than now prevail. Finally, it would reinforce a premium-based financing system that is more regressive than tax-based systems, it would not force more effective cost containment on the health system, and although it would regulate marketing of health plans it would not clearly provide methods of assuring user satisfaction or increasing accountability. These characteristics are inherent in an approach that relies on employer mandates to extend private insurance coverage, rather than developing a social insurance system through a public program like national health insurance. *Employer mandates should not be confused with national health insurance.*

Viewed as Medicaid reform, the Chafee proposal would greatly liberalize Medicaid eligibility and expand the base of political support for this vulnerable program. In these ways, it would undoubtedly improve this public assistance program. In most respects, however, the Chafee bill is the most limited of these proposals, emphasizing a welfare approach to filling gaps in coverage rather than opening the door to a universal social insurance program. Indeed, it might be perceived as an alternative to a true national health program, just as Medicaid was proposed as a welfare alternative to the social insurance approach of Medicare in the legislative debates leading up to their joint enactment (Brown 1983).

Political feasibility, at least in the short run, appears to vary inversely with the degree of change required by a proposal. On the basis of political feasibility one would be inclined to give greater support to the Kennedy-Waxman and Chafee proposals, less to the Roybal bill, and still less to the Dellums bill. These assessments could easily change, however, with changes in the Congress, the White House, conditions of health care access and insurance coverage, health care costs, and/or political efforts of proponents of one position.

This analysis suggests that the Roybal bill would provide the most social and health benefits with a modest degree of political feasibility.

Other analysts might rate each bill somewhat differently, but this framework provides some common ground for analysis and discussion. Both the substance and the feasibility of proposals might change as a result of that process, particularly as groups consider compromises to win support from potential allies and to neutralize potential adversaries. Deciding what compromises do not sacrifice one's fundamental principles is the difficult task which may be facilitated by systematic evaluation of alternatives.

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