

How Expenditure Caps and Expenditure Targets Really Work

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DURING ITS SEARCH FOR SOME FORM OF COST containment, the United States has speculated about the merits of “expenditure caps” and “expenditure targets.” Congress has instructed the executive to limit Medicare spending on physicians’ services by instituting Medicare volume performance standards (MVPS’s). Several bills for general health insurance reform introduced during the 1990s would create a government agency—a Federal Health Expenditure Board in the Mitchell–Kennedy HealthAmerica Bill is one example—for the purpose of recommending a national spending limit and dividing the allocation of health dollars among sectors. Americans must learn how to set and implement limits because a decision-making system instead of the current state of wishful thinking is necessary. The best insights are derived from countries with such systems already in place.

In this article I will distinguish (1) between caps and targets, and (2) between reimbursement methods to hospitals and to physicians, since they operate and are controlled in markedly different ways. A grasp of the details is required in order to understand the difference between successful and unsuccessful arrangements; a knowledge of past events is necessary in order to comprehend the present structural arrangements both in the United States and abroad.

Definitions

To clarify the nature of the spending limit, I will distinguish expenditure caps from expenditure targets, since they differ not only in meaning, but also in methods of implementation. Expenditure caps fit easily into certain sectors, but are less appropriate for others.

An expenditure cap is a fixed amount of money. All services delivered during the year are contained within that sum. If the organization or sector is nearing the total toward the end of the year, it must either deny some services or reduce reimbursement for every service. Caps imply strong control, usually with government authority. All money passes through either a single centralized payer or several highly coordinated payers.

Expenditure targets are goals for the current and, possibly, subsequent years. An agreement sets prices, based on the assumption of a certain level of utilization, in order to avoid deficits. Cost overruns would be covered the first year, but unit prices for the next year then would be set at less than the expected rate of inflation, in order to recover the loss. Targets imply a flexible and voluntary collaboration between private payers and providers, with government limiting its role to that of provider of information and guidelines.

The sector being limited must always be clearly identified in any discussion. An expenditure cap (or target) might apply to all health care spending in a country or to an individual sector, such as hospitals. Methods that work effectively to limit expenditures in one sector may not function well in another.

Spending control is a process. The initial stage of developing expenditure goals is distinct from the later stages of using caps or targets to implement them.

Research Methods

This summary of the evolution of expenditure policy and current methods in several European countries and Canada is based on my own original and repeated field interviews and observations over the course of 30 years. Complete information about statutory health insurance, national health services, reimbursement of doctors, payment of hospitals, and my research methods appear in my principal books (Glaser 1978,

1987, 1991). Basic descriptions of individual countries can be found elsewhere (see Roemer 1991).

Expenditure Policy

The Period of Expansion

For many years, the policy problem in health was to find more money. As national health insurance and public financing spread from country to country, hospitals were able to acquire skilled personnel and advanced technology; doctors gained more patients and higher incomes. Unlike U.S. Medicare in the days before diagnosis-related groups (DRGs), neither Canada nor any European country allowed hospitals and doctors to define their own needs or to charge sickness funds and governments completely according to their definitions of costs and appropriate incomes.

Every country developed methods for deciding reimbursement, with the arrangements differing among providers. Because hospitals were non-profit charities, the insurance and public financing systems were supposed to provide funds to cover their costs of appropriate care, without profits or losses. Depending on the country's reimbursement system, hospitals filled out retrospective cost reports and prospective budgets that were screened by neutral rate regulators (in France, Holland, and Switzerland), or negotiated with the sickness funds (in Germany), or screened by the single public payer (in Britain, Canada, and Sweden). The rates paid to each hospital were designed to ensure that it would break even (Glaser 1987).

The system for paying doctors differed because they sought incomes in excess of practice costs and would not reveal their expenses. Every country developed negotiations between medical associations and payers, resulting in standard fee schedules that would guarantee the profession's costs and additional income (Glaser 1978). Until recently, the expanding economies of these countries permitted steady growth in the amount of money paid to providers.

Limits

The euphoria about medical care and society's ability to support it ended during the 1970s. By then, all populations in Europe and in Can-

ada were covered either by national health insurance (either NHI alone or an NHI/private mix) or by a publicly financed program. All citizens had access to mainstream providers who no longer were afflicted by deficits, but instead continued to improve in capacity. At this point, government finance officers warned that they could no longer ask parliaments for a steady increase either in payroll taxes or in the subsidies to sickness funds recently instituted by some governments.

The methods for deciding the payment of hospitals and doctors were firmly in place, but during the 1970s they were supplemented by procedures for deciding and enforcing permissible levels of expenditure. By the 1990s all industrial countries with comprehensive systems of third-party coverage, revenue, and reimbursement—that is, all except the United States—had developed the machinery for setting and implementing financial goals.

Setting the Amount

It is not enough to say that costs must be contained. First, the acceptable level of spending must be established. During the periods of accelerated expenditure in the late 1960s and early 1970s, European and Canadian payers and rate regulators simply aimed to stay level with the rate of inflation affecting hospital budgets; in their negotiating papers, the doctors sought increases beyond inflation. It became common practice to increase the previous year's hospital budget and medical fees at least by the expected rate of inflation and to compromise on additional demands. Hospital rates and medical fees usually grew at a faster rate than inflation, and utilization grew as well; therefore, annual increases in health expenditure rose faster than the inflation rate, and health absorbed a steadily larger proportion of each country's gross national product (GNP) (Glaser 1978, 1987).

Government finance officers in every country—located in ministries for budget, taxation, and health—intervened in order to stabilize the payroll taxes and subsidies in insurance systems, the proportion of the government's annual budget that was spent for health in publicly financed systems, and the share allotted to health in the total resources of society. Methods of restraint became common, whether the countries used national health insurance or direct government payments, whether the sectors to be controlled were composed of hospitals or doctors, and whether the techniques of expenditure control were caps or targets.

From the census bureaus and economic statistics offices the finance officers gathered data about long-term trends in population structure, employment, wages, prices, and tax revenue. Then they estimated probable economic events for the upcoming year, particularly the probable yield from payroll taxes and the likely costs in several sectors analogous to health. Because these countries are democracies, however, the calculations by government finance officials and statisticians do not automatically dictate allowable increases in health care reimbursement. Providers make a case that their costs and work loads rise faster than other economic indicators, while users lobby for better services.

Negotiations Between Interest Groups

Germany. How each country decides its expenditure goals depends on its normal decision-making procedures and its organization of social services. For example, Germany has a long history of "corporatism" in its social and economic activities. Interest groups and social categories belong to associations whose leaders negotiate agreements with each other. The government sets ground rules and ratifies many of the decisions reached by the interest groups. Health is one of the several sectors governed by private intergroup relations with minimum government intervention. The national health insurance system preserves a private character: each sickness fund jealously guards its autonomy; each carrier (rather than a standard parliamentary tax law) decides its own payroll taxes; none receives government subsidies (Döhler and Manow-Borgwardt 1992).

When the explosion of health care costs strained the national health insurance system during the 1970s, Germany created the machinery for interest groups to study the facts and develop guidelines for the level of expenditure required to support good medical care without straining the health insurance system. Depending on their situation, individual sectors within health might vary in the amounts of financial increases and in changes in rules. Since the late 1970s, the Ministry of Labor (now the Ministry of Health) twice a year convenes a special commission with representatives from the sickness funds, the provider associations, the businessmen's federation, and the trade unions (the *Konzertierte Aktion im Gesundheitswesen*, or KA). The ministry staff summarizes government statistics about employment, wages, and the estimated fiscal capacity of the payroll taxes to cover health insurance in the coming year. A steering committee of university professors prepares reports about the state

both of the economy and of the health sector and makes recommendations for how health insurance should operate in the future. The next year's expenditure goals for the various health sectors are then negotiated within the commission. (The specific features of the KA result from the political history of the law of 1977. See Rosewitz and Webber 1990, 257-89; Glaser 1984, 322-9. The KA's operations and its relation to wider German institutions are described in Wiessenthal 1982 and Lehmbruch 1988.)

During their annual bargaining session, the German provincial sickness funds and associations of providers might agree on a greater or smaller increase than the KA guidelines for that sector. Usually, however, they settle on the recommended amount: the sickness funds resist paying more and the providers oppose accepting less. If the negotiators are deadlocked, the final award is decided by an arbitrator, who stays close to the KA guidelines recommended for the negotiations about expenditure caps (for doctors and dentists) and expenditure targets (for hospitals).

Implementing caps and targets depends both on cooperation and on the wording of the laws. The German medical associations cooperated from the start. The dental associations, on the other hand, refused to agree to guidelines for their sector during the first years of KA deliberations, and they would not sign provincial contracts requiring them to accede to KA guidelines that limited the annual increases in dental expenditure caps. The hospitals also balked, using their political leverage in Parliament at first to remain exempt from participation in the KA—despite the fact that they were principally responsible for the cost explosion that led to the formulation of the law of 1977. During the 1980s, that law was strengthened to include hospitals in KA deliberations and guidelines.

Government Initiatives

Even when government agencies officially set the spending goals, they do not dictate the outcome. Conflicts of interest between health care providers and the ultimate payers are debated within the ministries.

France and the Netherlands. Governments in France and the Netherlands play a bigger role than they do in Germany because they announce guidelines for regulating hospital reimbursement, enact standard nationwide payroll taxes, and subsidize the sickness funds heavily. The fi-

nance ministry is often the leader in drafting the targets because it is concerned with pressures either to raise health insurance payroll taxes or to provide subsidies for the carriers. In France, a committee of specialists from the ministries of finance, social affairs, budget, and agriculture works out guidelines every year, based on data showing trends in payroll tax revenue, health care utilization, and costs of the labor and supplies used by health care providers. Its aim is to link the annual increase in all health care spending to the annual increase in the country's GNP. Health thereby retains its relative position among society's spending priorities, instead of steadily growing at the expense of the others.

In lieu of a standing commission of the German sort, the French interest groups press their views through the ministries (Durieux 1990). The ministries do not merely reflect the views of government finance officers; they are also proxies for interest groups in the society. For example, the finance ministry is close to business interests and private insurance companies; the social affairs and agriculture ministries reflect the interests of sickness funds and patients; the social affairs ministry voices the concerns of the medical and hospital associations.

French hospitals—which are owned by local governments and screened by government rate regulators—adjusted to this methodology, but doctors never did. When the French medical associations, the sickness funds, and the government agreed on a target methodology in 1992, the doctors insisted on overt participation in goal setting. Therefore, an annual forum was created with representatives of the medical associations, sickness funds, and other groups, called the *Objectif Santé*, which was much like Germany's *Konzertierte Aktion*. When the medical associations and sickness funds meet for their periodic negotiations over money, they will have before them the guidelines and research reports of the *Objectif Santé* and the reports about the costs and fiscal capacity of social security produced by the respected independent *Commission des comptes de la Sécurité sociale*.

Independent Agencies

German and French experience demonstrates that, in the presence of a coherent decision-making apparatus, clear spending goals can be developed after give and take between interest groups. Modern democratic governments generally do not confer this responsibility on a single agency. Because the decision makers try to protect both the national

economy and the health insurance system, the spending guidelines tie the growth in spending to the GNP and to inflation. A completely independent agency, on the other hand, might adopt guidelines that would complicate wider public policy, as British experience demonstrates.

Great Britain. When health funding is publicly financed — as it is in Canada and Sweden as well as Great Britain — the government's budgetary strategy adds a new dimension to the general attempt to restrain the health sector's expanding share of the GNP. The government of the day may have one or several budgetary goals, such as keeping past election promises, appeasing indignant interest groups, reducing deficits and taxes, or strengthening competing priorities. The spending goals for health decline if the entire budget is squeezed or if rival priorities win. The decisions are coordinated but not centralized. As in all democracies, rival ministries and interest groups have their say, compromises are made, and the annual budget must be enacted by Parliament.

Hospitals become dominated by the government's general budgetary constraints, particularly when the government, as in Great Britain and Sweden, is the owner as well as the funder. Governments do not directly employ doctors under national health services and cannot dictate their pay increases. The same government that can formulate and implement a few simple financial guidelines for the hospitals may be unable to prescribe the criteria for guiding negotiations and arbitration with physicians, who continually press for more independence.

After decades of unsuccessful negotiations and political maneuvers, Great Britain during the 1960s created an independent arbitration agency to decide the annual pay increases: the Review Body for Doctors' and Dentists' Remuneration. The medical association and the Ministry of Health present arguments and facts, the Review Body announces an award, and the prime minister and Parliament are expected to agree. Because the Review Body is independent, it can adopt whatever criteria it likes and is not restricted to the budgetary limits and economic policies of the government of the day.

In making its submissions to the Review Body, the ministry has argued for pay restraint on several grounds:

- The government's budget must be balanced, all wage awards in the labor-intensive NHS must be limited, and doctors cannot be-

come an exception that will trigger new demands from the other NHS employees.

- The government's share in the GNP must be reduced, not increased.
- All wages must be limited throughout the economy in order to protect British international balance of payments, and a generous award by the government itself would touch off wage increases everywhere else.

The Review Body added other criteria of its own:

- Pay awards should be high enough to encourage new recruitment and discourage emigration.
- Doctors should be paid like other professionals and managers in the private market.

Like any arbitrators, the Review Body awards more than the government wants—at times much more—because it applies its own criteria. As a result, the government of the day occasionally repudiates the Review Body's guidelines, while insisting on its own, and refuses to implement the pay award. However, it then finds itself forced into a bruising fight with a coalition of the Review Body, the medical profession, and members of the other public and private occupations, who want higher pay as well. The Wilson Labour Government in 1970 rejected a generous award in order to protect its incomes policy, leading the Review Body to resign. During the next national election, which was fought over this and related matters, Labour lost to the Conservatives (Glaser 1978, 171–7). During the 1980s, the Thatcher Conservative Government scaled back the Review Body's award several times, a recurrent issue that contributed to the acrimonious atmosphere of that decade and resulted in the aggrieved British Medical Association becoming the principal obstacle to health service reforms in the late 1980s.

Implementing Expenditure Caps

A cap imposes the agreed-upon level of spending on the health care sector and expects all providers to operate within it during the current year.

Each provider must perform all its work, unsupplemented, within the limit, either that year or the next.

Hospitals

It is much easier to apply fixed limits to hospitals than to doctors. A hospital is nonprofit, reveals its costs and operations in a sworn report, and is responsible to auditors and regulators. Each hospital has unique operating costs, and, under national health insurance and national health services, its overruns can be monitored.

The model for expenditure caps is the global budget system of countries (like Canada, Great Britain, and Sweden) where the ministry of health gives each hospital a fixed annual sum. Each individual figure is part of the total for the hospital sector in the ministry's share of the government's entire budget. At one time, each hospital filled out a prospective budget and asked the ministry to approve it, but top-down budgeting has long superseded bottom-up applications. Every few weeks, the ministry sends a cash installment while maintaining a small contingency fund to help a few hospitals with unexpected extra work caused by disasters or epidemics. No money exists, however, for the average hospital's overruns; instead, it must make its own compensating economies (see Glaser 1980a,b, and 1987, chap. 8).

In the countries I have discussed so far, expenditure caps are paid by single government agencies. French experience, on the other hand, shows that expenditure caps can be used under national health insurance with several payers. Every French hospital since 1984 continues to submit its retrospective cost report and its proposed budget to the local government rate regulator, who screens and approves it, pursuant to the financial guidelines and limits prescribed in Paris. In periods of austerity, the national government may fix a cap for all hospitals in a region, and the rate regulator can award individual hospitals more or less than the guidelines imply, so long as the regional cap is not exceeded. The sickness funds in an area share the biweekly installment of the global budget for each hospital, in ratios equal to their shares in all admissions there last year (Glaser 1987, 19-69).

The first exercise in all-payer cost containment throughout the United States was an ill-fated attempt to impose an expenditure cap on the total inpatient revenue of the entire hospital industry. The Carter administration sought, through an act of Congress, to impose a maxi-

imum annual percentage increase on all hospitals' charges to all payers. Several formulas tied the annual increase to trends in the GNP. The method depended completely on the formulas and omitted the essential first step, adopted in France, of screening each hospital's prospective budget. The act's creators hoped that total hospital revenue would fall short of the inpatient cap; in order to avoid deficits, hospitals would try to shift business to the less expensive outpatient department.

The scheme proved to be the first case example of American health care policy makers' persistent inability to realize that a standing decision-making system must be created. Instead, they devised a scheme that consisted of unilateral government dictation: each year's cap would be designed in complete secrecy within the Department of Health, Education, and Welfare; after the announcement, providers and other interest groups could complain and lobby; finally, Congress would pass a law. The hospital industry was outraged. Even supporters of the Carter administration, such as the trade unions, were opposed because they lacked early input into the guidelines and caps. Two drafts of the bill were pigeonholed by Congress (Abernethy and Pearson 1979; Glaser 1979, chap. 13, 28-52).

Doctors

A good deal of recent American discussion about cost containment through expenditure caps refers to doctors, but foreign experience shows that doctors successfully resist caps. Financial settlements require negotiated agreements, and the medical association is willing to accept only standard fees and ground rules. Total costs result from fees multiplied by utilization, and a fundamental article of faith of the medical profession is that utilization depends on patients' free initiatives and on doctors' clinical judgments.

Great Britain's National Health Service has come close to imposing a strict annual expenditure cap on physicians' pay, only because doctors are not paid by fee-for-service. The general practitioners are paid capitation fees and specialists are paid salaries. Everything except their drug prescribing is predictable and stays within the annual budget. However, because the annual pay awards of the Review Body are not predictable, the cap must be set after the Review Body has spoken and its decision has been approved by the sitting government.

Germany

The only important expenditure cap on a medical profession paid by fee-for-service under statutory health insurance operates in Germany. The arrangement was never motivated by cost containment, but was created for other reasons, long before cost control became a great policy issue.

The German national health insurance law of 1883 gave the sickness funds full authority to provide care and did not specify the roles and rights of doctors. Medical associations hardly existed at that time. The sickness funds hired doctors as salaried employees and drove hard bargains. Relations between sickness funds and their doctors were tense and strikes were common. A solution originated in Leipzig during the 1920s: each sickness fund gave the amount of money available for ambulatory care during the year to a physicians' panel, and the doctors divided the cash themselves. The panel doctors welcomed the method because they could bargain collectively with the sickness funds and were no longer employees of capricious laymen.

These arrangements became universal under statutory health insurance in 1932. Instead of habitual arrangements between each sickness fund and its panel doctors, all financing was pooled. In each province, an "association of health insurance doctors" (a *Kassenärztliche Vereinigung*, or KV) negotiated with representatives of all the sickness funds for a fixed sum of money (a *Kopfpauschale*) that would apply to all ambulatory care for the year. Each sickness fund contributed to the pool according to the number of its subscribers. (A *Kopfpauschale* is a "capitation rate.") The KV then paid the bills of individual doctors, usually item-of-service fees that were calculated according to a relative-value scale that was created and constantly updated by negotiations between the national headquarters of the provincial KVs and the national associations of the provincial carriers. The national negotiations did not fix the "conversion factor" or its annual updates, but the levels of fees varied according to the fiscal capacity of the provincial sickness funds and their negotiations with the provincial KVs. The local sickness funds could no longer drive individual bargains with doctors and divide them. The KVs, not the sickness funds, processed all the bills, monitored utilization, and guarded against deficits. Although doctors had to operate collectively under financial limits, nevertheless their ability to administer the cap was preferable to being employed by the sickness funds (Naschold 1967; Döhler 1987).

Individual office doctors competed to gain larger shares of the fixed sum. They developed a practice style of holding long office hours, using labor-saving equipment and auxiliaries, and working rapidly. Many itemized services were provided at low fees, but the doctor's total income could be high: in order to protect the average doctor's income and the pool's solvency from suspicious overbilling, the KVs identified doctors who collected high incomes by submitting unusually large numbers of bills (the *Kassenlöwen*). Long before the introduction of computers, the KVs could identify outliers by calculating a profile of each doctor's billing and measuring it against that of the average physician. Throughout Germany, the KVs paid only parts of the *Kassenlöwen*'s totals. The KVs had the last word, and the *Kassenlöwen* could only file internal appeals. If the pool still faced a deficit, the KV was authorized to prorate everyone's conversion factor downward during the last weeks of the year ("degressive fees"). The medical profession did not agree to this system out of a desire to protect statutory health insurance from a cost explosion, and it was far from their ideal of unfettered individual practice, but it was a collective alternative to something physicians viewed as worse: employment by the sickness funds. These methods prevailed from the early 1930s to the mid-1960s.

German experience demonstrates the drawbacks in imposing an expenditure cap on doctors paid by fee-for-service. The *Kopfpauschale* system was said to motivate each doctor to work rapidly and sloppily and was thought to encourage unnecessary multiplication of acts and submission of false bills (Maiwald 1968, 47-50; Herder-Dorneich 1966, 282-6, 294-6). The system was a large closed panel: a fixed ratio of doctors to subscribers ensured that doctors were added at the same rate as the system's ability to pay them—preventing doctors from flooding in and depressing average incomes—and guaranteed that the sickness funds would not be pressed to add money merely to subsidize a glut. The medical profession outside the KVs protested, the sickness funds gradually increased the ratio, and finally in 1960 the outside doctors won a lawsuit declaring that the limit unconstitutionally prevented them from practicing their occupations (Papier 1985). As part of a general reform in 1965, the *Kopfpauschale* system was replaced by full payment for each act, the normal method in all other countries. A fee schedule with predictable rates was adopted. The sick funds agreed to pay every bill at the full rate. The KVs continued to administer the office doctors' claims and were reimbursed by the sickness funds according to the agreed-upon fees.

For the next 20 years expenditure targets were administered as strictly as caps. However, during the 1980s, the sickness funds and the government grew concerned that physicians' services would not be restrained forever. Utilization steadily grew and physicians' service mix became more complex and expensive. As part of several reforms of statutory health insurance during the 1980s, the national headquarters both of the sickness funds and of the KVs, jointly with the national Ministry of Labor, decided to reform the payment of office doctors (Brenner 1990). Spending often gets out of hand during periods of reform and, because Germans prize both low inflation and predictability, outright expenditure caps were temporarily reimposed on physicians' services. Their terms, as negotiated between the sickness funds and the KBV, were specified in contracts signed in June 1985. The government's only contributions were reliable data and encouragement. In the age of the computer and after long experience, the "social partners" devised more sophisticated expenditure caps:

- As in past years, each province had its own *Kopfpauschale* because each had its own level of revenue.
- The *Kopfpauschale* no longer mixed all subscribers. Because pensioners were more expensive than other subscribers, and because sickness funds had different proportions of pensioners, the carriers paid into the KV-administered provincial pool one standard capitation rate for each pensioner and a standard lower capitation rate for each employed person.
- Each carrier's payments to the pool were calculated by the quarter at approximately the rates it had paid during the same quarter for the previous year, updated for inflation. The procedure was outlined in the national contract of June 1985, but the actual financial details were settled by provincial negotiations between the sickness funds and the KV. As always, the KVs argued that increases in utilization and service intensity justified higher *Kopfpauschale* payments than the inflation trend.
- The *Kopfpauschale* no longer covered all procedures in the same way. Even before the June 1985 contract, laboratory medicine had been placed under its own aggregate expenditure cap and assigned its own relative values schedule and methodology of degressive fees. Another high-tech field with a reputation for exaggerated multiplication of services—electrodiagnostics—was now also reimbursed under a special *Kopfpauschale* that it might not exceed.

- Each KV expected to operate within each quarter's cap. Utilization review continued to be applied to the Kassenlöwen. If a quarter's limit was exceeded, rapid computerization now made it possible to degress all fees quickly at the start of the next quarter. Therefore, total expenditure for the current year would stay close to the annual limit—the essence of a cap. Limits to offset overruns would not be delayed until the next year—the essence of a target system.
- The special sickness funds for the white-collar workers, managers, and self-employed (the *Ersatzkassen*) for the first time paid into their own Kopfpauschale. Although their conversion factor and fees remained higher than those of the other sickness funds—a tactic to obtain more solicitous medical service—any overruns in utilization and costs triggered a degression of their fees by the KV, thereby closing a persistent exception to general cost-containment policies.

The negotiations to modernize the fee schedule yielded modest results, and the sickness funds, KVs, and provincial governments retained the new Kopfpauschale methods well into the 1990s.

Canada

Experiences in Canada demonstrate the great difficulty in imposing an expenditure cap on the medical profession by simple fiat. The country has full public financing for the services of physicians and hospitals, and the provincial ministries have imposed strict global budgets on all hospitals. No province, however, has been able to treat the doctors in this way. The provincial medical associations insist on negotiating fee schedules and conversion factors with ministries of health or—during the early years of Medicare—with special commissions for administering physicians' claims that were designed to act as buffers between the doctors and the ministries. The results are compromises somewhat short of outright caps (Glaser 1978, chap.2; Lomas, Charles, and Greb 1992).

Quebec. Canadian experiences again show that, if the medical profession cooperates with caps, it has really designed them itself in order to avoid what it considers a worse outcome. For the general practitioners of Quebec during the early 1970s, the specter was the provincial government's proposal to direct family medicine away from traditional fee-for-service office practice into community health centers staffed by salaried doctors and auxiliaries. The change was expected to improve the quality

and availability of care; it would also limit costs, already one of Quebec's principal problems. The very high incomes earned by some doctors came in for special complaint.

The association of general practitioners that dealt with economic interests (the *Fédération des médecins omnipraticiens du Québec*, or FMOQ) had to appease the Ministry of Social Affairs and the social reformers who pressed for community clinics. The FMOQ had to make office practice less vulnerable to public outcry. After 1975 it offered a ceiling to restrain excessive income: for every three-month period, a maximum individual income from billing the official reimbursement agency would be proposed; over that income, the general practitioner would collect only 25 percent of the full fees. Total spending for all physicians' services from all sources would not be limited. The essence of an expenditure cap—degressive fees for all bills if a predicted total was approached—would not be involved.

This arrangement was not only modest but, during the mid-1970s, gave away very little. Quebec obtained an exemption from the national government's even stricter wage and price controls over all other occupations; therefore doctors' reimbursement in Quebec unexpectedly rose faster than incomes in private employment. High-earning doctors would lose much of their income anyway under rising general tax rates. The province slowed its promotion of health centers.

Quebec's ceiling method has never been repealed and is rarely challenged. Any potential complaints have been averted by a growing number of exceptions. Even if he or she has reached the ceiling, the GP can collect full payment for deliveries, sessions for workmen's compensation, and some work in community health centers and nursing homes. The earnings ceiling is 15 percent higher in underdoctored areas. Many Quebec doctors welcome the ceiling system as an excuse to take Caribbean vacations after busy and well-paid trimesters. Patients complain that their regular doctors are unavailable at times, leading them to burden hospital emergency rooms. The Quebec expenditure cap may not save much money because the fees are not generally degressive, the reimbursement agency is burdened with administrative work, and some patients must use hospital emergency rooms. However, it reduces income inequalities among doctors and it increases opportunities to new entrants.

Ontario. Events in other provinces also demonstrate that government—however beset by budget strains—cannot impose strict caps on

the medical profession, but instead must persuade the doctors to accept a settlement. Several governments of the day in Ontario during the 1980s tried to impose fee freezes, regardless of inflation. The Ontario Medical Association (OMA) called administrative strikes and protested in the mass media. The voters in 1990 picked a new government (led by the New Democratic Party) that pledged it would improve relations with the medical profession, negotiate agreements on fees and utilization, and accept binding arbitration of disputes.

A contract signed by the Ministry of Health and OMA in 1991 provides for annual negotiations to set an annual increase in fees by a certain percentage, covering expected growth of the population, higher utilization due to aging, inflation, and improvement of income. If actual expenditure exceeds the allowable cap, all doctors' revenues from their combined Medicare billings are reduced for the entire year by half the percentage excess. (For example, if the allowable increase was 7.5 percent over the previous year's expenditure and total billing by all physicians was 8.5 percent, then the final payments to doctors for the year are limited in order to bring the total for the profession only 8.0 percent higher.) All disputes are settled by an arbitrator selected by the chief justice of Ontario, who follows procedures prescribed by the province's arbitration act.

The Netherlands

Dutch experience demonstrates yet again that the medical profession will accept only the expenditure controls that it freely negotiates and that the members approve. Under statutory health insurance, governmental attempts to impose caps trigger automatic resistance.

During the 1970s, when Dutch health insurance costs exploded, the sickness funds were strained and excessive incomes by medical specialists were blamed. During the early 1980s, the association that represented all medical specialists (the Landelijke Specialisten Vereniging, or LSV) tried to defuse the controversy by negotiating several agreements with the association of sickness funds (the Vereniging van Nederlandse Ziekenfondsen, or VNZ). A cap would be placed on the highest earners, not on all claims. The physician would collect full fees for the first f.200,000 of billing under statutory health insurance; he or she would refund to the sickness funds one-third of the next f.50,000 and would refund two-thirds of all billings over f.250,000. The same method

would apply to pathologists, except the amount of their refund would be two-thirds of any amount over f.225,000. Radiologists who performed more than 10,000 tests a year under statutory health insurance were asked to refund a part of any fees they collected after completing the 10,000 tests. A special office jointly directed by the medical association and the sickness funds was to administer the program. A similar agreement governed specialists' billing of the private health insurance companies.

The method was never implemented because the rank-and-file doctors would not cooperate: most refused to report their incomes and few sent refunds. The national government exacerbated the situation by trying to convert the bilateral agreements into public policy: the agreements and their formulas would be approved and enforced by the public commission that set rates for hospitals and other organizations and that had previously only rubber stamped the LSV-VNZ contracts (the *Centraal Orgaan Tarieven Gezondheidszorg*, or COTG). The state secretary for health and his associates indicated that the limit on high earners was a stopgap, and that they would eventually seek legislation creating an expenditure cap and degressive fees as in Germany. Such government intervention infuriated the specialists and their leaders in LSV, and in 1986 they conducted an unprecedented one-day strike. Their mood worsened when the state secretary issued a regulation instructing COTG to reduce all specialists' fees, on the grounds that practice costs were covered by the sickness funds' payments to the hospitals and that the carriers should not have to pay twice. LSV filed lawsuits against this intervention by the state secretary and called strikes. The courts held that the state secretary and COTG had exceeded their authority, but also ordered an end to the strikes.

In this charged atmosphere, the medical associations and the sickness funds were left to settle the issues by negotiating a new contract. The goals were to control costs (as the VNZ and government wished), avoid fixed annual caps with degressive fees (as LSV insisted), minimize the role of government, and preserve private decision making. After several years of difficult negotiations, the Five-Party Agreement was signed in early 1990. An expenditure target methodology was adopted. For a few years, until new calculations can begin, all fees have been frozen at their 1989 levels. Once total expenditure for all specialists' services in 1989 have been calculated (by the trusted National Bureau of Statistics and not by the partisan Ministry of Health), it will become clear whether to-

tal spending has increased. If it has, the national offices of both the sickness funds (VNZ) and the private insurance carriers (KLOZ) will identify from their aggregate claims data the specialties most responsible for the growth. The annual negotiation meetings will then freeze, or even reduce, their fees for the following year, whereas other specialties will be granted the usual increase. Cuts will apply to all doctors in the specialty, not to the high earners alone.

Implementing Expenditure Targets

Expenditure caps seem appropriate to publicly financed hospital services—as in Canada, Great Britain, and Sweden—because all government programs must operate within their budgets. When national health insurance is restrained by expenditure goals, it almost invariably uses targeting methods. One reason is that providers are reimbursed by units rather than by global budgets. Another reason is the resistance to caps by the medical profession. As the events in the Netherlands demonstrate, doctors resist cost containment by caps, but compromise on targets.

Hospitals

The traditional method of reimbursement has been to screen the prospective annual operating budget, estimate the expected number of patient days, divide the total budget by total patient days, and bill all sickness funds for the standard patient-day charge throughout the next year. If the hospital runs deficits, it might persuade the rate regulator or the sickness fund to increase the per diem for that year; more often, the deficit is covered by a surcharge on the per diem for the following year.

When cost containment was enforced during the 1970s and 1980s, per diems were still being calculated and used as the unit of reimbursement. However, after other methods for establishing expenditure goals for the hospital sector were set, the rate regulators and negotiators were supplied with guidelines designed to contain the annual increase for each hospital within the annual expenditure goals for the entire health and hospital sector. Each hospital's revenue consisted of the number of actual patient days multiplied by the approved per diem. The hospital was at risk if operating costs exceeded revenue because it was unlikely to

get a supplement; the method was intended to force economies. The hospital might gain a short-term profit if its operating costs were low. The health insurance system was at risk of cost overruns if the number of patient days exceeded predictions. Under a target methodology, regulators and payers study the reasons for recent cost overruns and adjust the next agreement. The rate regulator and sickness funds press the hospitals to reduce their operating costs so they break even under the next year's prospective budget (Glaser 1987).

Such has been the targeting method in hospital reimbursement in France, Germany, Holland, Belgium, and Switzerland. A question arises concerning choice of guidelines that govern the target. In Germany—as in the other countries—the approved budget and rates were supposed to cover the hospital's legitimate costs. The sickness funds and rate regulators often challenged the hospitals' representatives regarding certain budget lines that they thought were inflated. Gradually the fiscal capacity of the sickness funds was introduced into the negotiations about rate regulation. (One example would be the guidelines provided by Germany's KA.) While preparing the reform of German health insurance during the late 1980s, the finance officers in the national government and sickness funds wanted to insert clauses that explicitly instructed the fund-hospital negotiators to fit their awards into the expected fiscal capacity of the sickness funds, rather than merely cover the increases in operating costs expected by the hospitals. The hospitals' numerous political allies blocked enactment of such a change, leaving the carriers and hospitals free to continue bargaining over all guidelines.

The laborious screening of prospective budgets failed to produce reliable targets in every country because the unit of payment was the per diem. Once the target was settled, any unexpected increase in utilization produced surplus earnings for the hospital and high losses for the payers. In order to enforce the expenditure goals with minimum risk of cost overruns for the payers, France substituted global budgeting in 1984.

Doctors

Negotiations between the sickness funds and medical associations start with the expenditure goals and spell out the details of how to implement them. Even after participating in goal setting, the medical associations try to extract more money from the sickness funds in the final

negotiations. The sickness funds are responsible for the final contract and for juggling their budgets to cover concessions. Even in France—where the sickness funds are public corporations and the Minister of Social Affairs must approve the contract and fees—the sickness funds have minds of their own. However, medical associations are gradually participating in budget enforcement after decades of resistance followed by many recent protests, as in the Netherlands, against government threats to impose caps.

France

During the 1990s the once fiercely independent medical associations of France agreed to help implement targets. They insisted on a negotiating system for setting goals and achieving targets instead of merely emulating the substantial role of government in making payments to hospitals. During the 1990s, a new intergroup forum, the *Objectif Santé* will examine reports and recommend desirable levels of health care spending. After the ministry and sickness funds sign an agreement adopting the guidelines, the usual negotiating sessions between sickness funds and medical associations will take over, but their goals at that point are to adopt statistical targets and methods of implementation. Instead of the ad hoc documents and arguments of the past, the contract, signed in 1992, specifies the reports and evidence that will be on the agenda: guidelines and special reports from the *Objectif Santé*, trends in social security spending on all programs, particularly health, the expected yield of the payroll taxes, the size and age structure of the population, trends in disease, expected progress and cost increases in medical technique, the size and structure of the medical profession, among other items.

The negotiators then bargain from their self-interested positions and try to settle on compromise targets. For 1992, the negotiators agreed on a 7.09 percent average increase, varying among clinical sectors. About one-third of the expected increases in aggregate spending covers the monetary increase of fees, and about two-thirds covers the expected increases in utilization. (For example, the allowable increases for general practitioners' office and home visits from 1991 to 1992 were 2.18 percent in price, 5.05 percent in volume, and 7.34 percent altogether.) In each locality, the joint committee of medical associations and sickness funds then writes a plan for containing costs, so the national targets are

achieved. The local plans compare past trends in spending with the expected reductions in the rates of increase. The national leaders of the medical associations and sickness funds then synthesize the local plans into a national scheme that describes changes in medical services and the expected financial outcomes.

Restraints will be enforced by perfecting several existing methods. Profiles will identify medical specialties and individual doctors who have exhibited wasteful practice tendencies. Cost-effectiveness research will pinpoint medical procedures that should be abandoned or used more selectively, with the aim of discouraging them in the local plans.

Fulfillment of the targets will be monitored by the national associations of doctors and sickness funds. If the targets are exceeded without clinical justification, fees in future years will not increase as expected in order to recapture the excess. All disputes are settled by an arbitration commission: votes are equally divided between the doctors and the sickness funds, and they pick an impartial chairman, who has a deciding vote. The result is a system of payer-doctor collaboration inconceivable several decades ago in France.

Canada

Quebec. How a target is carried out in its present joint carrier-doctor form varies among countries. The French start with utilization control to reduce the less cost-effective methods. If that does not succeed, annual increases in fees may be restrained—the method that sickness funds long used in their bargaining positions. If fees are restrained to compensate for cost overruns, the limits may apply to all doctors.

Alternatively, the targets and the limits may vary among specialties. This method produces unforeseen complications, as Quebec demonstrates. Negotiations between the Ministry of Social Affairs and the representatives of all the specialists (the *Fédération des Médecins Spécialistes du Québec*, or FMSQ) have always produced the fee schedule and its annual conversion factor. Quebec has imposed global budgets on hospitals and has capped the earnings of some general practitioners, but no expenditure caps have ever been imposed on specialists. However, since the mid-1970s, Quebec's chronic budgetary problems have led to agreements about expenditure targets for specialist services. If increases in utilization and service intensity produce cost overruns in one year, the target for the next year is set below the ex-

pected inflation rate and the anticipated increase in private-sector professional salaries.

The negotiators agree on a total sum (a *masse monétaire*), which, when divided by the total number of specialists, produces a desired average gross yearly income. In 1990 this was about \$170,000. The distribution among specialties results from negotiations between their leaders within FMSQ. Some specialties earn more than the overall average (i.e., more than \$170,000), some less. The leadership of FMSQ—like that of medical associations everywhere—has always preferred to narrow the spread among specialties. The result is to raise the cognitive specialties relative to the surgical and technical fields. However, the final decisions must be made by the interspecialty negotiating committees within FMSQ. If the overall expenditure target is exceeded and if the increase in the *masse monétaire* is limited accordingly, FMSQ then tries to distribute the restraint unequally among the specialties. For example, if the current annual target had been increased 4 percent by the negotiators, but actual spending rose by 5 percent, and if the *masse monétaire* for the next year accordingly was increased by only 3 percent, FMSQ might try to give an increase of no more than 1 or 2 percent to the surgeons and radiologists, whereas the internists and psychiatrists would see a gain of 4 percent. Each specialty's target average income and fees therefore increase the following year at a different rate. If this year's total expenditure target is not exceeded, the ministry and FMSQ agree on a full increase for the next year, and all specialties experience the same rate of growth.

Implementing targets in this manner produces one expected political complication: the surgeons, obstetricians, orthopedists, radiologists, and anesthesiologists protest their smaller annual increases. The powerful general surgeons seceded from FMSQ for a while and hoped the others would follow, thereby breaking up FMSQ. But the Ministry of Social Affairs refused to negotiate separately with the general surgeons, FMSQ continued to make the decisions about fees that governed the ministry's reimbursement of surgical claims, and the surgeons were forced to resume participation within FMSQ. The hematologists also seceded for a while and then rejoined. Representing the medical association requires political skills, not only to extract more money from the payers, but also to reconcile rivalries within the profession.

Achieving targets in this manner produces one unexpected technical complication. When the negotiators from the ministry and FMSQ first

created Quebec's fee schedule during the early 1970s, it had a single list of relative values. The annual financial deliberations attempted a standard increase in the conversion factor for all specialties, but by the late 1970s these methods were undermined. When cost overruns restrained the total increase, and when FMSQ tried to apply the update by assigning different weights to the specialties, simple differentials of the conversion factor between the specialties were not enough. In each specialty, certain procedures were performed frequently and were the key to the provision of that specialty's income. For example, general surgeons earned a lot from cholecystectomies; cardiac surgeons earned a high proportion of their incomes from bypass surgery; gastroenterologists earned a good deal from colonoscopies. The statisticians and physicians within FMSQ planned a target income for each specialty by focussing on its key procedures; they changed the target incomes in the annual updates by shifting the relative weights of the procedures for those specialties alone. By now, the weights have nothing to do with the work for each procedure, but are artifacts that (when multiplied by the expected number of procedures) yield a target income. There is no longer a simple, comprehensible fee schedule for all specialties; rather, each specialty has its own version. Payments for the same procedure (such as a lung biopsy) will differ when it is done by a general surgeon rather than by a thoracic surgeon because its weight varies according to the fee schedule of each specialist.

Effects

Hospitals

Through global budgeting and strict rate regulation, nearly all developed countries (although not the United States) now regularly limit the range of annual increases in hospital spending to between one-and-a-half to two times the annual rate of inflation. At times a country can limit growth among hospitals to the inflation rate alone (Glaser 1987, chap.13; 1991, 435-6).

Global budgeting is not automatically stricter than rate regulation. It depends on how the systems are administered. Health care has long been one of the priorities of Swedish public policy and—until the austerity of the 1980s—the national and regional governments gave large increases to the hospitals. Rate regulators receiving strict guidelines from

the national government can limit each hospital's prospective budget so that the hospital sector's share of the GNP declines, as Dutch experience during the 1980s demonstrated for a time (Maarse 1989). Germany's hospitals have a long history of low staffing, low pay, and long work hours, and German sickness funds have continued to negotiate tight budgets after a temporary cost explosion during the early 1970s (Alber 1990).

Doctors

It is impossible to limit physicians as strictly, particularly if fee-for-service is used. Their spending cannot be kept at a constant share of the GNP because their sector is demand driven: patients are free to visit doctors and request treatment as often as they wish. At the same time that the aging of populations increases utilization, scientific and technological advance substitutes more expensive treatments. The medical profession resists simple cost reimbursement or flat-rate payment methods. Despite the profession's cooperation with current strictly administered expenditure targets in Europe and Canada, the annual increase in physicians' spending during the 1980s nevertheless came to twice the general inflation rate. In the United States, it was triple (Glaser 1991, 437-8).

An important reason for the steady increase in spending on physicians is the regular growth in the numbers of doctors. Whereas the government finance officers and sickness funds press for expenditure goals that will stabilize the health sector's share in the total economy, the medical association has a different aim: to protect the income of the average doctor. No capping or targeting system ever tries to reduce this income, either globally or by specialty, because the medical association would refuse to negotiate it. A consequence is that the payers are forced to supply more money as the number of doctors grows. Countries with apparently strict capping and targeting methods—like Quebec and Germany—have annual increases in total spending for physicians that more than double their inflation rates, largely because the number of physicians is expanding (Hughes 1991).

Germany

The German reform of 1965 permits a comparison of expenditure caps and targets in physicians' services. Germany adopted the more custom-

ary method of negotiating financial values for each procedure: paying each fee in full, and then limiting the subsequent year's increases if unexpected growth in utilization and service mix produces cost overruns in the current year. During the first decade, the sickness funds postulated their own informal targets, merely to avoid deficits; after 1977, they based their financial negotiations on the KA guidelines.

Despite relaxation of the expenditure cap, physicians' spending did not skyrocket. The annual nominal increases from 1950 through 1965 averaged 14.1 percent, and the annual nominal increases from 1966 through 1975 averaged 13.6 percent. (These are based on my calculations from the annual German statistical yearbook, *Kassenärztliche Bundesvereinigung*, or KBV.) Expenditure caps are not inherently stricter than targets implemented by negotiations—it depends on how each is administered. The sickness funds in all provinces insisted that the KVs continue to detect and limit payments to doctors who submit very large numbers of bills. In many provinces, the sickness funds and KVs agreed that, if unpredicted increases in utilization and service intensity exceeded the expenditure targets, the KVs would pay degressive fees during the final months in order to reduce the general conversion factor on all bills. An expenditure target system—in theory more permissive than a simple cap—became stricter than any method heretofore imposed on the medical profession: the annual nominal increases in the cost of physicians' services from 1976 through 1985 averaged 5.7 percent (my calculations, based on the annual KBV).

Comparison with Medicare

Congress has enacted a target system for Medicare. The Physician Payment Review Commission (PPRC) conducts research into inflation, practice costs, trends in utilization, technology, and Medicare physician expenditure, as well as other factors. PPRC recommends a possible update in the financial level of all fees (the "conversion factor"), depending on inflation. PPRC also reports several years' trends in utilization, service mix, technology, and other factors bearing on program cost; it calculates an MVPS, the excess expenditure over a level recommended by public policy. The Health Care Financing Administration (HCFA, on behalf of the Secretary of Health and Human Services) then recommends to Congress an increase in the conversion factor, which could be

reduced by a few percentage points from the initial PPRC recommendation if the MVPS over five years has reflected a substantial excessive growth in program costs that strains the budget of Medicare Part B. Congress has the last word. If Congress does not legislate, a “default formula” determines the following year’s update: HCFA’s recommended update of the conversion factor, less a differential between the excesses in MVPS’s over five years, less 2 percent (Physician Payment Review Commission 1990, chaps. 11,12; Rice and Bernstein 1990).

Claims that the designers studied and emulated the methods in other developed countries—particularly Germany and Canada—are not true. Expenditure targets are now unavoidable and are common in all developed countries, but the American scheme differs as follows:

- MVPS refers to Medicare alone and does not apply to other payers. Cuts in Medicare reimbursement will lead to a common American tactic: shifting costs to other payers. Some doctors may reduce their load of Medicare patients, as they already do in response to the disappointing Medicaid fees. In contrast, every other country’s target system applies to all-payer or single-payer reimbursement.
- MVPS will become so complicated that it cannot be administered: there will be separate MVPS calculations for every state, for surgical and nonsurgical services, and for certain special groups of physicians. In contrast, every other country standardizes rules.
- MVPS relies on so many esoteric formulas that it cannot be understood and will invite recriminations and lawsuits. Officials involved in its enactment and administration give different versions and express uncertainties (U.S. Congress 1991; personal interviews with informants). In contrast, every other country develops methods that can be easily understood by providers, payers, government, and the mass media.
- The Medicare target is dictated by the government, ultimately through an annual act of Congress. The medical profession does not negotiate, but at best only supplies “input,” through testimony at hearings of PPRC and Congress, and through visits by its lobbyists. Statistics, targets, and rate reductions produced by unilateral government action will be denounced every year by the doctors (see many issues of the *American Medical News*). Other countries set targets by intergroup discussions and use negotiations in any final reimbursement decisions involving the medical profes-

sion. British experience shows the pitfalls of government dictation to the medical profession.

- Responsibility for decisions is not fixed in either one agency or in one negotiation forum. Rather, the Department of Health and Human Services (i.e., HCFA), the Office of Management and Budget (OMB), the PPRC and Congress participate. Each will develop its own recommendation based on different criteria—as the tumult during the latter half of 1991 demonstrated. Some will be more generous to the doctors (especially PPRC), others will be stingier (especially OMB). The division and the changes during the successive stages will fuel uncertainty and controversy.
- As in all its decisions, Congress will produce a final outcome each year derived from political log rolling. Typically, the resulting reimbursement legislation will satisfy no one and will be too complicated to understand.

Summary

Every organized payment system must contain its costs in order to keep within revenue without denying benefits. Fixed expenditure caps requiring the provider to operate within its annual financial grant can be imposed on organizations like hospitals, but are fiercely resisted by the medical profession. All financial arrangements with doctors are negotiated, including systems of fixed expenditure caps and more flexible expenditure targets. If the doctors accept the principle of caps and cooperate in achieving them, they do so only as part of a negotiated settlement to avoid a worse outcome. Government's power is minimized, even when government is the payer.

Caps on the physicians' sector are unusual. Instead, we see the spread of flexible targeting systems, wherein cost overruns are compensated for by lower expenditure targets the following year. Medical associations in all countries resisted even these restraints for years, but eventually accepted them, provided that target setting, judgments of overruns, utilization control, and all other features are part of a joint negotiating system. Targeting systems are often complicated because they preserve the semiprivate character of statutory health insurance and they are the result of negotiated compromises. To succeed in controlling costs, they require the cooperation of the medical association and of the rank-and-file doctors—but they can succeed.

The United States has enacted a small-scale targeting system for Medicare physician payments alone. It cannot become the method for universal health insurance, which must heed lessons from abroad. Only an all-payer system can cover an entire population and contain the costs of the system. A few government officials cannot dictate and implement expenditure goals, but a system of consultation is required for setting and carrying out targets. Impartial officials can regulate hospitals according to the guidelines produced by the consultations, but the record of the medical profession in the countries reviewed here is that they insist on negotiating the final rules and rates. Americans have become bewitched by the mirage of econometric formulas automatically governing a sector, but the real problem is to devise and operate a harmonious decision-making system.

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