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NATIONAL HEALTH INSURANCE

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- o What's happening in the USA and the rest of the world?
- o What does it cost and who pays?
- o Britain is changing -- back to private insurers?
- o What are we going to do?

MR. JOHN C. HARTNEDY: In talking about National Health Insurance I feel we are very fortunate to have with us two Ph.D.'s in economics. Both of these people have done considerable research in National Health Insurance, not only in the U.S. but in other countries around the world. Our third panelist is an actuary who has worked in the U.K. for more than 15 years, so he has lived with National Health Insurance and he will give us yet a little bit different perspective on National Health Insurance.

DR. JOHN C. GOODMAN: I would like to begin by addressing two principles that apply to all developed countries whether or not they have National Health Insurance. It is important to keep in mind when we think of how health care systems of other countries operate. The first is that in the U.S. and every other developed country, we could in principle spend 100% of our gross national product on health care. And we could spend it in such a way that the last dollar spent would still be adding something positive to the health care of the people. There are virtually unlimited ways in which we can spend money in this field. We can do 900 tests just on blood alone so you could go in each year and have 900 tests done on blood. You could go in each year for a brain scan. Probably, just in the area of testing alone, we could spend 25% of the gross national product. Because there are virtually unlimited ways in which we could spend our health care dollars it is very misleading when we talk about health care being free to patients in other countries. When you talk about something being free, it sounds like it's an off-the-shelf item; that you just walk down the aisle and decide what you want, take it, and go home. In fact, we know on principle that that sort of thing cannot happen. Other countries cannot give their citizens all the health care that they want. When the price is zero and people are aware of what medical science has to offer, the demand for health care is virtually infinite, or if not infinite then beyond the resources of countries to provide. Therefore when we look at the health care systems of other countries that have National Health Insurance, we should keep in mind that what we are really looking at are ways in which the government keeps people from acquiring all that they would want to acquire if there were no charges and if they were aware of what medical science could do for them. The study of National Health Insurance is really a study of the ways in which the government denies people health care that they might otherwise want.

The second basic principle applies to all these countries and states that there is not in medical science any rigorous definition of what constitutes necessary medical care. There is nothing in science that says that a medical test should be done and is necessary if it has a 1 in 100 probability of providing you with useful results and which should not be done if the probability is only 1 in 10,000. Not only is there no definition of what constitutes necessary care but we don't have any way of ranking care so we can say this is the first most necessary thing that you would want

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to do, this is the second and this is the third and so on. Not only do we not have any definition of what constitutes necessary medical care or any way of ranking all the things that we can do according to some scale of necessity, it is further true of all the countries in the world that there is no mechanism in place to assure that those who are most in need of health care, by whatever definition we use, are those who get the health care. None of these countries have any mechanism in place to assure that those who need health care the most are those who are treated first. Therefore when we look at these other countries, we should keep in mind that we are, number one, focusing on how health care is rationed (how are people denied things that they otherwise would want), and number two, if health care is not distributed on the basis of need how is it distributed in these countries.

If health care is free to patients at the time of consumption, it necessarily must be rationed. And essentially there are two ways that you can ration health care. Number one, you can just refuse to provide the service to anyone. Number two, the most common approach, is to provide it in limited quantities; in other words you make it available, but not available to all the people who want it or could benefit from it. And when you do that then you have rationing, most commonly by waiting. People stand, if you like, in a theoretical line in order to get the health care. In Britain, there are 800,000 people on the waiting list for surgery in British hospitals. In New Zealand, which is a country that has a population about the size of the greater population size of Chicago, there are 50,000 people on the waiting list for surgery. Many of these people wait in pain for years for a needed hip replacement or gallbladder surgery; many of them are risking their lives by waiting. It often makes headline news in Britain when a heart patient dies while he is on the waiting list waiting for heart surgery that his physician said he needed. We're beginning, incidentally, to see those same kind of newspaper stories in Canada where we have heart patients on the waiting list for bypass surgery who die. For some reason the newspaper reporters find that very newsworthy. Britain and New Zealand are two countries who actually try to keep count by the way of how many people are on a waiting list for surgery. Most countries don't even do that. So we go to a country like Canada and we can't find some official document which tells us how many people are waiting. But surveys have been done of British doctors to give us some idea of what's going on up there. For example, in the providence of Newfoundland right now, to get a hip replacement you would be waiting about six to ten months; cataract surgery, the wait is now about two months; Pap smear the wait can be up to five months. Even for what doctors call urgent Pap smears the wait is at least two months. For a computerized axial tomographic (CAT) scan you are looking at about a two-month wait.

The longer Canada goes with the experience of National Health Insurance, the more and more its problems begin to resemble those of Britain and New Zealand and other countries that have had National Health Insurance for considerably longer periods of time.

What do people do when they live in the system in which they have to wait for health care that they want and which doctors say they need? Those who can do so turn to the private sector and what we've seen both in Britain and in New Zealand, who have had four years of experience with socialized medicine, is a growing demand for private health insurance. Right now in Britain 12% of the population pays premiums to buy private health insurance even though health care is theoretically free to everybody in the country. In New Zealand one third of the entire population has private health insurance and private hospitals in New Zealand now perform 25% of all of the hospital surgery. What happens is these people are essentially paying for health care twice. They are paying once as taxpayers to get the free care which is then not given to them, so then they go into the private sector and buy that which they theoretically have already paid for.

How is health care rationed? How do these countries decide where to spend their money? My position on this is if we want to understand how other countries make decisions in the health care marketplace, we need to understand politics and quit listening to intellectuals who argue on a theoretically level about what's interesting to intellectuals and start looking at politicians and the pressures that are put upon them. The ways these systems operate are totally and exclusively determined by political pressures and the democratic voting system. And one of the realities a politician is going to confront very quickly when he starts allocating health care dollars is that modern medical technology is expensive; life-saving technology is expensive. What you end up doing is spending a lot of money on just a few patients and there is very little political benefit in doing this.

What's the alternative to investing in modern medical technology? The alternative is to spend money in such a way that you create very small benefits for large numbers of people, so that large numbers of voters are affected by the spending policies that you chose. That is invariably the kind of pressure that is put on politicians. Consider Britain, the country which actually invented CAT scanning technology. In 1980 Britain exported more than half of all the CAT scanners used in the entire world and they did it with subsidies from the government. Yet the British National Health Service buys only a handful of CAT scanners for its own people, probably one of the lowest rates of purchases in all of Europe. Here is a country that invented the technology, sends it all over the world for other countries to use, yet won't buy it for its own people. Britain was a co-inventor, along with the U.S., of the dialysis technique that we use to treat kidney patients. So now we are able to keep patients alive who have chronic renal failure who otherwise would have died. And yet Britain uses the dialysis technique very sparingly in Britain. In fact it has one of the lowest dialysis rates in all of Europe. It's lower even than Italy and it is the country that invented the technique. In Canada you can see the same thing. A bias against technology and a lack of willingness to spend money on expensive procedures even though they may be lifesaving procedures. The city of Seattle, which is right across the border from the province of British Columbia, has more CAT scanners than the entire province of British Columbia in Canada. The state of Michigan has more magnetic resonance imaging (MRI) devices than the entire country of Canada. The province of Newfoundland with a population of 570,000 people has only one CAT scanner for the entire province. In order to get to the CAT scanner you go through primary care physicians and then a specialist and still you have a two-month wait to get to a CAT scanner in Newfoundland.

In looking at the rate and extent in which countries that have government-run health care systems make use of modern medical technology, I was able to focus on three technologies which were developed during the 1970s. First was the cardiac pacemaker, second was the CAT scanner and third was the treatment of patients with chronic renal failure, either with dialysis or with a kidney transplant. Just to give a few numbers, in 1976 when pacemaker technology came of age, the implant rate in the U.S. was 22 times the rate in Canada and four times the rate in Britain, on a per capita basis. CAT scanners per capita in the U.S. show twice the rate of use of Canada and almost six times the rate of use in the U.K. Kidney patients have a 70% higher rate of treatment in the U.S. than either Britain or Canada.

What does this mean for patients? For patients who are denied access to lifesaving technology it often means they will simply die. A few years ago the Brookings Institute did a study of British health care and compared the treatment rates for lifesaving technology with treatment rates in the U.S. Compared to what we do in the U.S., in Britain each year about 9,000 kidney patients are denied treatment and die. As many as 15,000 cancer patients are denied cancer chemotherapy. As many as 17,000 heart patients are denied coronary artery surgery. Those are the lifesaving procedures and that does not include the more routine kinds of surgery such as the 7,000 people who do not get hip replacements in Britain each year. Compared to the rate at which we make those types of surgeries available in the U.S., there's a bias against modern medical technology.

What about inequality in health care? The standard thing you hear from intellectuals who like to talk about National Health Insurance is what happens in Britain is a system set up for poor people. You hear that throughout Europe. Nothing could be further from the truth. National Health Insurance is not about poor people. That needs to be understood from the outset. In all these countries, like the U.S., they had a program for poor people, however good it was. What happened in these countries is the same thing that is happening in the U.S. today. The middle class working population is getting squeezed because they have to pay the taxes to pay for the health care for the elderly and the poor and in addition to that, these expenditures help drive up health care prices for the health care which they purchase. So the middle class is bearing the whole burden of the program and getting none of the benefits.

National Health Insurance is a program for the middle class. It puts everybody into the same waiting line, if you wish, and the middle class is far more effective than either the poor or the elderly in getting to the head of that waiting line. As far as the inequality issue, numerous studies have been done on the distribution of health care resources in Britain and every study has concluded that inequality of health care is widespread in Britain. The last study, the Black Report, said that after forty years, there is just as much inequality of access to health care in Britain as there was in 1948 when the British National Health Service was started. I don't know

of any evidence that convinces me there is any more equality of access to health care in Canada or Britain than there is in the U.S.

Primarily what we're talking about when we talk about National Health Insurance is not equal access to health care. Interestingly, it is my conclusion that the biggest victims of the rationing schemes are the elderly and the poor. When health care has to be rationed, when doctors and hospitals make decisions about who is going to get care and who is not, it is the poor and the elderly who tend to go to the end of the line.

Consider some statistics on the elderly. Across Europe, generally, about one of every five dialysis centers refuses to give kidney dialysis to kidney patients who are over 55 years of age. In Britain, 35% of the dialysis centers refuse to treat patients who are over 55 years of age. Forty-five percent refuse to treat patients who are over 65 years of age, and if you are 75 years of age in Britain it is virtually impossible to get dialysis. Now one thing we know about our kidneys is they don't get better with age. So whatever the instance is of chronic renal failure at middle age we know it's bound to be higher among the elderly population. But if you look across Europe generally the treatment rates for people at middle age are much higher than treatment rates for people who are older. In fact, there is an inverse relationship between treatment for chronic renal failure and the age of the population group. So if you go to a country like West Germany, the treatment rate for treatment of kidney disease for middle-aged patients is nine times greater than the treatment rate for people 75 years of age and older. In France, it's three times greater for people of middle age. In Italy, it's eight times greater for people of middle age. And I've already mentioned that if you are in Britain and 75 years of age you virtually cannot get treated if your kidney goes out, unless you're the Queen or maybe Margaret Thatcher.

What does all this mean in terms of mortality rates? I believe, along with other health care economists, that mortality rates don't tell us very much about the health care system because most of the reasons we are likely to die have nothing to do with what doctors are doing or what hospitals are doing. So it does not surprise me at all that life expectancy at birth in England is not much different than it is in the U.S. But I do believe that as we get older the health care system begins to matter more. And I do believe that among the elderly the health care system probably matters a lot in determining how many extra years of life that you have.

Therefore, I looked at the mortality rates for the elderly in the U.S. and other countries. I found in comparing the U.S. and Britain, for white males age 65, the life expectancy is 1.3 years longer in the U.S. than it is in Britain even though at birth life expectancy is the same. I discovered across Europe generally that among males 25 to 35 years of age mortality is lower in almost all European countries than it is in the U.S. This is mortality from natural causes. For some reason that I don't understand males in the U.S. age 25 to 35 are just really vulnerable. But I discovered that when you get out among the elderly, when you go out to people age 75 years of age and older, the U.S. has the lowest mortality rate. I don't know how much of that can be attributed to the health care system but I suspect that some of it can be.

Let me address the issue of efficiency in health care. There is a widespread myth you see everywhere in the popular press and in the technical literature, that the way you can judge efficiency in health care is by looking at the percent of GNP spent on health care. Among developed countries Britain spends about the smallest percent of its GNP on health care. That is often taken to mean Britain is really efficient. Just from a theoretical point of view, if you stop to think about it, you'll see that the percentage of national income, or GNP spent on health care, has nothing to do with how efficiently dollars are used.

In many of these countries like Britain and Canada, the government simply makes a decision about how much money it is going to spend on health care. Canada has decided that its percentage of GNP spent on health care is simply not going to rise. And over the last ten years it hasn't risen. Now any government that controls the health care dollars could in principle say this is all we're going to spend. That's no great feat to say here's the number of dollars that you can have and that's all we're going to spend. That has nothing whatever to do with efficiency. From an economist point of view, efficiency is how you spend the dollars. If you go to Britain and you look at the health care system, you don't see anything that resembles efficiency.

I remember not long ago I went into a British hospital. I went in the laboratory and it compared reasonably well with laboratories and hospitals in the U.S.; in other words it was a good

laboratory. Then I walked down the hall to the radiology department. That radiology department looked like a radiology department you would have seen in the U.S. back in the 1930s and you probably can't find anywhere in the U.S. today. And here were these two departments in the same hospital. Of course, what was happening was that the guy that headed the lab was real good at hospital politics and the guy who headed the radiology department was really lousy at hospital politics. You can find British hospitals side by side, one has a surplus of nurses. I have been in a hospital ward in a British hospital where there are elderly patients who were chronically ill, who are not in need of a lot of attention, and there was almost one nurse for every patient. The hospital next door was saying we can't do surgery because we don't have the nurses to help us. That is not efficient use of health care dollars.

Consider the following. Although in New Zealand 50,000 people are on the waiting list for surgery and hospitals at any one time, one of five hospital beds in that country is empty. In Britain while 800,000 people are on a waiting list for hospital surgery at any one time, one of every four beds is empty. And in both countries, in both Britain and New Zealand, one of every four beds that is full is being filled by an elderly patient who is chronically ill and really doesn't need to be in the hospital. This same kind of pattern is now occurring in Canada, where I understand that the Canadian hospital administrators fill their beds with chronically ill patients because they believe they are less expensive to take care of and this is how the hospital administrator keeps his expenses down.

One last point on these health care systems. Where is the money spent? They don't want to spend it on modern medical technology so where do the dollars go? Consider the following fact. In England last year there were 21 million ambulance rides. That is almost one ambulance ride for every two people in the entire country. Eighty-three percent of these ambulance rides were for non-emergency purposes. Many of them consisted of nothing more than picking up an elderly person and taking that person down to the pharmacy to get a prescription filled. The ambulance service in Britain is like a free taxi service. Many of these ambulances don't have the kind of modern equipment that we have to take care of genuine emergencies. A lot of money is being spent on free taxi service.

There is an extensive home health care system in Britain almost lavish by U.S. standards. A lot of money is being spent on services that go out and affect a lot of people, while the hospitals, from our point of view, are literally being starved.

How much does it cost to save the life of a kidney patient in Britain? What does it cost to keep one more kidney patient alive? It costs $15,000. I mentioned earlier about 9,000 kidney patients a year are not getting this treatment and therefore presumably die. At the same time the British National Health Service is spending $70 million a year on tranquilizers, sedatives, and sleeping pills, $19 million a year on ambulances, $21 million a year on cough medicine, which is then given free to patients within the system. The British politicians like to spend money in ways that affect large numbers of people and they do not like to spend a lot of dollars on what we in the U.S. would consider really necessary health care.

DR. ALDONA E. ROBBINS: I am an economist and I'd like to bring some economic perspectives to the health care problems and policies in the U.S. today. As an economist, I believe that freely determined prices are the most effective rationing mechanism and this goes for health care as well as for any other goods and services. Any attempt to disguise or abandon prices altogether requires some other form of rationing.

As John Goodman has already discussed, rationing shows up in long lines or giving up decision-making power to other people. During the post World War II period, however, I think there have been forces at work in this country to either disguise or abandon altogether the price system for health care. And I think these attempts have resulted in problems that we are all familiar with today. We have runaway medical inflation, we have health insurance premium costs that are increasing at 20 or 30% a year in spite of the Medicare program which is 8% of a $1.1 trillion federal budget. We still find the elderly spending a larger share of their income on health care than they did before Medicare was enacted, which of course was one of the reasons we had the Medicare program, to limit the health care expenditures of the elderly.

The attempts that we have had at abandoning the price system I think are based on two incorrect premises. First of all there is this notion that somehow there is this absolute need for health care rather than discretionary demand.

Therefore, the solution is for the government to assure equal access, whatever that means, to health care for all regardless of income. In other words, the government and not the marketplace should somehow distribute health care on the basis of need and finance this distribution on the ability to pay. If this sounds like a collective approach, that's because it is. But collected approaches have traditionally been anathemas to Americans; they just don't seem to buy that kind of solution. So a proponent of this kind of approach has to present it in a more palatable fashion. In the case of health care, as has been done with Social Security, one proven disguise is to mislabel government involvement in health care as insurance.

What is the purpose of true insurance? We have individuals who face risks from financial catastrophies that can come from all sorts of different sources, including extremely high medical bills. As an individual I can prepare for these risks by setting aside enough resources to meet that eventuality, but knowing that possibility is very small. Or I can go and find some other individual with the same risk and have him share them with me and that reduces the amount that you would each have to set aside. Or we can find an insurance company that is actually acting as a broker for a large group of individuals and reduce the amounts that we have to set aside even more. The insurance company will charge each of us a premium. The premium has essentially three components. First of all it has to cover the average expected expenditure for the members in the group. Second the premium has to include something for risk, in other words, the chance that I'm going to be wrong on predicting my average expenditure and that two years out of three I'm going to be able to meet actual expenditures with the premium that I charge. And then I'm going to have to charge something for the cost of doing business and overhead and normal profit. I think we have to remember the risk premium component is extremely important. Without it consumers would be charged too little to insure against the risk of medical expenditure, and faced with a lower price we know that consumers will demand more health care than if they were faced with a true higher price. As a result we would consume too much medical care.

How does our government insurance program or approach measure up to these insurance principles? People within the policy-making machinery of Washington who advocate greater government control of health care justify those actions on the basis that the government can do it cheaper. And their prime example is the Medicare program. Medicare is an entitlement program for the elderly, disabled and people with end-stage renal disease. Medicare Part A pays essentially all hospital costs after a deductible which is $560 this year and it's financed by a payroll tax that is 2.9% on wages and salaries up to $48,000. Enrollees, people who are insured, pay no premiums whatsoever. Medicare Part B pays 80% of all covered outpatient services such as doctor visits and diagnostic tests after a deductible of $75. It is financed by premiums collected from enrollees and from general revenues.

The Part B premium is set each year by the Health Care Financing Administration or HCFA that administers the Medicare program. It's based on the average cost per enrollee that HCFA is projecting for the next year.

The Part B premium though does not contain the necessary risk premium to reflect the true cost of insurance. While the HCFA actuaries do include something called a contingency margin, this adjustment is retrospective and not prospective. In other words Part B enrollees are penalized or rewarded after the fact. In summary, Part A enrollees in Medicare have their premiums totally subsidized by American workers. Part B enrollees also receive a substantial subsidy. When all is said and done they end up paying only 25% of the cost of Part B. The rest comes out of general revenues. Because 63% of all federal general revenues comes from wages and salaries, we can say that American workers pay for the majority of Part B health insurance or Medicare as well. In spite of this analysis, you will hear that Medicare is still a good thing. Advocates claim that it is fair or equitable to redistribute income from those who can pay, presumably workers, to those who can't pay, presumably the elderly. Moreover, the redistribution is costless to the economy as a whole. This conclusion is wrong for a number of reasons. First of all, by disguising, lowering the true cost of health care to Medicare enrollees, we find that too many of society's scarce resources are being devoted to Medicare-covered medical services. And this increased demand has contributed to the rapid rate in medical inflation. Since 1948, 50 cents out of every extra dollar spent on health care has gone to an increase in prices, not an increase in output. Since 1965, when

Medicare was enacted, 62 cents out of every dollar has gone to an increase in medical inflation. In other words, we see an even faster acceleration in inflation since the Medicare program.

Second, the redistribution of income from workers to the elderly is not costless. As I said, Medicare is financed by taxes on wages through a payroll tax and an income tax and such financing is not a free lunch. Any increase in labor taxes reduces the take-home pay of workers, leads to a reduction in labor supply and an increase in the cost of hiring labor. If we look to the future, I find the picture fairly frightening. Expenditures for Medicare Part A and Part B are going to increase much more rapidly than any other part of the federal budget. The Congressional Budget Office projects a 90% increase over the next five years. That's from $87 billion in fiscal 1989 to $165 billion in 1994. There is no other part of the budget that is growing anything like that. Furthermore, if you look at the trustees reports, you will see that beginning about 1992 the Medicare Part A payroll tax will be insufficient to meet benefits that will have to be paid out. In other words, the program is going to start running deficits. These deficits continue on out forever and grow over time.

Unless we do something about controlling benefits, we are looking at higher and higher tax rates. We've estimated that as a result of the 1988 and 1990 Social Security payroll tax hikes, which went from 14.3% in 1987 to 15.3% in 1990, the U.S. economy will generate a half-million fewer jobs, 320 billion less output by the year 2000, and perhaps most importantly of all, our capital stock, our saving, will be $100 billion lower than otherwise. But compared to the future tax increases that are going to be needed to fund the present Medicare program, the 1988 and 1990 increases are peanuts. Larger tax increases will have even more devastating economic effects. For example, last year Claude Pepper had a home health care bill that proposed eliminating the $48,000 wage cap for the Medicare tax alone, 2.9% of the payroll tax. That action would lead to 200,000 fewer jobs.

Third, I think there is a gradual change occurring in public opinion. It's no longer accepted that the elderly are poor as a group and workers are better off as a group. In fact, I think that we are seeing evidence that the opposite is true. And I think that the settling in of this economic reality helps explain why the catastrophic coverage act that was passed last year took on the particular financing mechanism that it did. In other words, the benefits for this new Medicare program will come from a combination of premiums paid by enrollees and taxes on enrollees. The redistribution is now going to occur among the elderly as a group, rather than from workers to elderly.

Although the catastrophic act has been sold as a great bargain, it is not and policy-makers will say that obviously the government does it cheaper. This is wrong because the administrative expenses that are charged to the Medicare program understate the true cost. They do include salaries of government workers, but they don't include other things, like cost of capital for example, which are elsewhere in the budget. Second, private insurers have to incur expenses such as taxes and marketing cost that the government doesn't. Of course the government doesn't have to worry about marketing Medicare, because the program is mandatory. It seems absurd to me to claim that the government saves us money by taking away freedom of choice. I would prefer to pay the marketing cost and have some say in what kind of insurance I get.

The other major component not included in government accounting is the risk premium. It's true that the government is in a different position than an insurance company, because if the insurance company consistently guesses wrong on its premium, it will find itself out of business. If the government guesses wrong, it has a captive customer base called the American taxpayer and it simply raises taxes. However, whether or not we acknowledge it, the government does face risk costs just as it did when it underwrote or guaranteed the deposits of savings and loan associations. Whether it be health care or the savings and loans problem, the taxpayer may be forced to pay the cost after the fact. We really should not ignore the cost.

I think apart from a very likely alteration of the catastrophic coverage act sometime during the next year, the Congress is unlikely to expand any government health care program directly either this year or next. The reason is that there is simply too much pressure to balance the budget or reduce the federal deficit. But we do hear in the papers and the media about the growing concern for 37 million uninsured. And we also hear about the growing bills of uncompensated care that are faced by, in particular, public hospitals in inner cities.

Last year Senator Kennedy introduced a bill that would require employers to provide a minimum health insurance policy to workers who work at least 17.5 hours a week. The minimum benefit package would have covered most of the medical expenditures covered by standard policies. It would have had a deductible of $250 for an individual and $500 for a family. Now compliance with a bill of this type would increase health insurance cost. The increase in cost would depend on a number of things.

First of all, what would the premium be for this new mandatory package? To what extent would the new mandatory package exceed packages that were out there already, so that employers would have to upgrade? At least initially, the legislation contains some changes in the insurance contract which would bring about some added costs. Then there would be administrative expenses as well. In the summer of 1987 we produced some estimates of the original cost of the Kennedy bill and last year after the bill was amended and voted out of the Labor and Human Resources Committee, we updated those estimates and that was put out by an National Center of Policy Analysis (NCPA) study that is available. Our new estimates assume that the bill would take effect in January 1991 and indicated that workers would have to spend somewhere between $108 billion and perhaps up to $150 billion more on health insurance. When you consider the fact that the uncompensated care that could be addressed by the Kennedy bill would be on the order of $4 billion, it seems a little bit foolish to spend between $100 and $150 billion to address a $4 billion program. But, that's my arithmetic.

There will be severe economic consequences as well: 1.1 million fewer jobs and the economy $27 billion a year less in output. An interesting budgetary phenomenon would be about a $45 billion drop in federal tax revenues because switching compensation from wages which are subject to payroll and income taxes to employer-provided health insurance would substantially cut revenues to the federal government.

In Massachusetts last year, you may all remember from the presidential campaign, Governor Dukakis had a version of mandated health passed in that state that is going to tax employers 12% of wages and salaries up to $14,000. But there is a maximum tax of only $16.80 and given rising health insurance cost you may find some employers deciding just to go ahead and pay the tax and forget the health insurance. That would be counterproductive to what was originally intended.

Let me just summarize by saying that mandatory health insurance on either the state or national level does have serious economic consequences. It increases payroll costs and alternately reduces employment, it distorts the pay packages of many workers and it reduces tax revenues. Furthermore, mandatory benefits are erroneously being advertised as being free, because under current accounting conventions they don't show up in the government budget, but they are not free. They result in the same identical adverse effects as if the government would have taken the money through taxation and spent it directly. Furthermore, there is another danger off in the distance; when actual market premiums and the true economic cost of mandated health insurance turn out to be higher than expected, there will be claims the government could provide the insurance more cheaply. That leads to further government intervention and alternately what you're talking about is a true national health insurance program.

Where we are in terms of mandated health insurance is that Senator Kennedy will reintroduce his bill in this Congress. From all the reports that I see there is very little interest in really moving it forward. So it's unlikely at this point that much action will be taken at the federal level. However, I understand that there are about ten states where the Massachusetts approach is being considered, so we might see more action at the state level. I think due to what I've said about the Medicare program and the fact that there is an intensive pressure to balance the federal budget, we're not going to see any new national health insurance program, although I do see in the press and a number of groups have issued reports this year that are talking about that kind of approach. But I don't see anything like that happening at least near term.

I would like to end by saying that, while I criticize everything in Washington and when you do that, they say, "Well, Dr. Robbins, what would you do; it's not enough just to criticize, what would you do?" My notion is that there is a role for the government to play and that is to address the concerns of the poor and I see health care catastrophes as being somehow related to income. For example, in the catastrophic bill a catastrophe is defined as $1,370 in Part B expenditures. If I'm a widow living on a minimum Social Security benefit check in West Virginia with $3,000 a year in income, I reach a catastrophe a lot before $1,370. But if I am part of a married couple living in

Boca Raton, Florida with $100,000 a year in income, $1,370 really isn't a catastrophe. So the approach that I see is to do something through the tax system where one would define a catastrophe; the government would take responsibility for a catastrophe in medical care in terms of a catastrophe being defined as related to income and then let the private sector handle everything up to that point.

MR. GEORGE C. ORROS: I would like to share with you an insight into the health care scene in the U.K. My views are not going to be totally the same as what was presented previously by John Goodman, but I imagine that is hardly going to surprise you.

Now as some of you may know there has been considerable debate in the last few years in the U.K. about the future of the National Health Service. Some of us, in spite of what John Goodman said, still believe that it is one of the best health services in the world. I'll just take a more pragmatic view and point to the frequent stories in the press and the media of patients sometimes having to wait a long time for hospital treatment. Some commentators like to compare the situation here in the U.S. with that in the U.K. They point to the far higher spending per capita in the U.S. and the short waiting list for treatment. They say that the National Health Service in the U.K. is underfunded. By the end of the day, however, it is recognized that it is the taxpayers who fund the National Health Service and that political considerations are quite important. Despite the health care spending in the U.K. being considerably less than what is being spent in the U.S., it is still true to say that nobody is uninsured. Everyone is entitled to free health care, irrespective of their means to pay for the treatment. Those with additional resources can pay for ancillary services, like private rooms and perhaps a higher quality hospital and perhaps easier access to the hospital sector, but the medical care they receive whether it's public or private is essentially exactly the same. In fact, for life-threatening conditions I think it is generally accepted that the public sector provides a superior service to the private sector, partly because of its extensive back-up support services. Some people feel it would be nice if the same could be said about the U.S.

I would like to cover three broad areas with you. The first is public and private health care. Then I'm going to say something about the recent government proposals to change National Health Service which have been published recently in a white paper called "Working for Patients." And finally I'm going to say a few words about the future role of private health insurance.

First of all, I would like to begin by putting the U.K. into context with other countries around the world. These are figures from 1985 published by the Organization for Economic Cooperation and Development (OECD) and what they show is that back in 1985 the U.K. spent about 5.9% of GNP on health care whereas in 1985 the U.S. spent about 10.8%. We've heard earlier that the current spending in the U.S. is about 12% of GNP, whereas in the U.K. I don't think it has changed much from 5.9%, so we spend a great deal less on health care than other countries, particularly the U.S. and less for example than some of the major European countries, like France, Germany, Italy, Netherlands, Spain and Sweden. However, when you look at what the public spends on health care rather than what the private sector spends, a different picture emerges. Although some of the European countries spend more on health care, the public sector components of their spending are not that much higher. We spend roughly, in public terms, about 10% less than the OECD average and the big difference in those figures is that the private spending in the U.K. is a great deal less than in other countries and that is something that the government would like to rectify.

Another way of looking at the size of the private sector in the U.K. is to look at the proportion of the total money that is being spent in the private sector. The proportion of National Health Service spending total decreased from about 92% in 1984 to about 88% in 1988 and over the next few years that proportion is going to decrease further.

The National Health Service has been a major political issue throughout the 1980s. I suppose the general public has increased expectations of timely high-quality treatment and has become less tolerant of administrative excuses for having to wait for hospital treatment. In fact one of the problems of the National Health Service is its sheer size and high proportion of non-medical staff in health service. The National Health Service employs more than one million people. That makes it the third-largest employer in the whole world, bigger than any other employer in the whole western Europe and bigger than any employer in the U.S.

One of the reasons for the large number of employees is the management structure of the National Health Service. As you can see, the proportion of administrative and clerical staff has doubled in the last 25 years, as has the proportion of professional and technical staff and the proportion of medical and dental staff; i.e., real professionals are only about 4%, which is about 50,000 people.

Another big issue is demographic aging of the population. The proportion of money that is being spent on the age group 75 and older has increased from just over 20% in 1973-1974 to more than 27% in 1984-1985 and is clearly set to increase more rapidly from now on. We estimate that we need to increase National Health Service funding by 1% a year in real terms purely to keep pace with the demographic aging of the population.

It's in this context that I'm going to talk to you about the private health insurance industry, which has grown rapidly in the last few years. Twelve percent of the adult population now has proper medical insurance over and above their entitlements to free health care from the state. The market penetration varies from about 6% for the over 65s to about 17% for people age 45-54. It's likely that the proportion over 65 with insurance will grow rapidly from next year onwards as a result of what the government is about to do.

If you look at other risk attributes apart from age, you find that males are more likely to be insured than females and married couples more so than singles. Now faced with the growing unrest in the National Health Service, the Prime Minister announced at the beginning of 1988 the government was going to undertake a very major fundamental review of the National Health Service. After more than a year of deliberating, in a White Paper entitled "Working for Patients Tax Relief," the idea of having self-governing hospitals and family doctors having a much greater prominence in the delivery of health care in the country was presented. Health authorities are going to start funding rather than providing care and there is going to be a huge amount of decentralized decision-making done from now on.

Let's start with tax relief for the elderly. Legislation is being introduced to give income tax relief for anybody aged 60 or older from the next fiscal year which starts April 1990. This is very much an initiative by the Prime Minister, I think, rather than from the rest of government. The White Paper concluded that a key factor in the development of the private health care sector has been the spread of medical insurance, and although the number of people insured in recent years has gone up quite a bit, it has been largely as a result of companies insuring their employees. The difficulty here is when the employees reach retirement age not many employers wish to continue paying the individual medical insurance premiums for the retirees. Now the government sees this as a major problem and to alleviate the cost is going to introduce tax relief for next year. The tax relief will be to not just the elderly, but to anyone who pays their premiums and I think the feeling is that many families will start paying the medical insurance premiums of their elderly relatives and get the full income tax relief including high rate relief if they are high earners. It is really all designed to alleviate the cost of medical insurance in old age.

The next area is self-governing hospitals. Now what's going to happen here is that the large acute-care hospitals with more than 250 beds around the country are going to be encouraged to become self-governing. They are going to call them National Health Service Hospital Trusts. While they are going to technically still be within the National Health Service, self-governing means they decide what they want to do and are still be able to have contracts with the private sector as they wish, run their own affairs and generate as much private income as they possibly can. I think self-governing is very much government phraseology; in other words, it might be independent or even private.

The next thing that is going to happen which is quite important is that family doctors are going to have a much greater prominence in the delivery of health care in the country. Group practices looking after 11,000 or more patients to begin with, a limit that will come down in future years, will be allowed to opt to hold budgets for the National Health Service in respect to all their patients to be spent as they think fair in the public or private sector. These budgets are going to cover things like out-patient treatment, diagnostic tests from hospitals and any sort of discretionary elective surgery. If the general practitioners don't spend all their budget, they will be able to keep half the savings themselves to build up their own practices, partly so they can provide more services themselves. The idea is to let the family doctors have a much greater say in what goes on and to basically control the funds on behalf of the patients. What this really means is that we are going to move away, I think quite quickly, from having a state rationing system by which

the money is provided into fixed amounts and people have to wait. It's just saying that the money is going to stop following the patients through the allocation of these budgets. And that if the family doctor decides to use a particular hospital, then that is where the funds go and if he decides he doesn't like a particular hospital, then the funds just won't go there and that hospital will have to do something about it or go out of business.

This is really leading to a lot of internal markets and competition within the health service, with the health service becoming much more a funder of care rather than a provider of care. Basically they are trying to shake up the organization to be more commercial than it has been in the past. Many people feel the use of family doctors, essentially as gate keepers to the access of specialist and hospital, is going to be a very good cost containment measure. In the U.S., the public always had a much greater access to specialists, any specialists they like and any hospital they choose, and some would say that they pay the price for that free access.

To summarize on this issue, the health authorities are going to start funding care rather than providing care. Rather than running hospital services themselves with their own direct labor organization, the funds will be spent in one of three provider areas. One is the directly managed National Health Service Hospitals, the second is going to be the self-governing major acute-care hospitals and the third is going to be independent hospitals. Each one of those three parties is going to compete for the work. If they compete well, they will get some, and if they don't, they will go out of business. This also leads to the proposals to, as far as possible, decentralize decision-making within the health service. The responsibilities of the district and regional health authorities are going to change so that they can fund rather than provide care for the patients within their jurisdiction. Instead of running hospitals, the health authorities are going to be purchasers of care from the public and the private sector, and will be competing with each other as I've just outlined. So under this decentralization there is going to be a new policy board that is going to set the strategy and the objectives for the health service and the responsibility for all operational managers is going to be moved away from politicians to revamped National Health Service management executives who will be accountable to the policy board for the management of the National Health Service within the strategy and objectives that are set by the policy board. The role of the regional health authorities is going to change to be one of strategic management boards that would no longer have day-to-day operational management responsibilities. They will move away from the authorities to hospitals themselves as far as possible.

So what it all comes to really is that the White Paper, or the legislation surrounding it, is going to have a major impact on the private health insurance industry.

So what is the future role? I think the government would like to increase the private health sector to be much more like the norm for European Community countries, which indicates a tripling in the size of the private sector with the government component staying where it is now. There is always going to be a major public sector and the private sector is going to have to collaborate with the public sector if it is going to be successful. The key role of the private health sector is going to be to supplement rather than compete with National Health Service services. A major component of these supplementary services is going to be the pre-funding of non-urgent medical and surgical treatments. As regards the increase in the total size of private spending to more likely norms, there are some practical measures that can be taken to help the government in this direction.

The first is going to be self-funding private insurance. Many prospective policyholders have existing medical conditions and they will choose to self-fund rather than buy insurance and hence cut out the middleman and get better value for their money. Employees are going to be encouraged by those first tax devices to cover the whole of the work force rather than just the management grades. So we are going to see a broader range of products, so they cover the whole work force. Families are going to be encouraged, as we have already outlined, to cover their elderly relatives on their individual policies.

The introduction of budgets for family doctors, these are National Health Service budgets for their group practices, is going to encourage the emergence of family doctor insurance coverage, because that could be a great deal cheaper than using specialists and expensive hospitals for treatments that could happen within an outpatient setting. So there is a big opportunity here for low-cost insurance to supplement what the state funds will allow to be bought. There is going to be major market growth which is going to come from the emergence of these affordable mass

market products and the focus is going to be on supplementing National Health Service, not competing with National Health Service.

In terms of the product designs which are going to emerge, one is going to see products which only cover non-urgent medical and surgical treatments where there is a waiting list. The government is going to be issuing a list of these treatments for the purpose of the budgets for family doctor group practices. That is likely to form a basis of some low-cost insurance products. The products may also provide hotel services for those who want to buy such services, which could include private rooms, better choice of meals, personal televisions, personal telephones and other such amenities for a patient in the hospital. All those things have a price and could be bought in a supplementary product.

There is also going to be much greater choice of which doctor and hospital you go to. In practice, the family doctor is going to channel the patients to the appropriate specialist and hospital and act as a gatekeeper in such services.

On the pre-funding side, this is going to be achieved in a variety of different ways. The first is what we call fixed-price surgery, whereby you know in advance what it is going to cost once you know the diagnosis.

The second area is going to be as a result of the tax relief coming in from next year, i.e., a major boost to pre-funding short-term care. There is also a possibility in the longer term, although the government hasn't yet decided on this, to start giving incentives for long-term medical insurance products to enable the public to pre-fund the health care in old age by building up savings before the age of 60. On the large employer side there is going to be more self-funding because that is more cost-effective than using an insurance company.

With regard to coinsurance deductibles, this is one area that you probably find strange, but coinsurance is not yet a common feature of products in the U.K. But as a means in the future of controlling cost, it clearly has an important role to play. We are already seeing a fair number of PPO networks being formed, with products around those which essentially are going to give full reimbursement if you use the PPO and 90% reimbursement if you don't. That is a very noble feature still in the U.K., but we think it is going to grow quite a bit.

In the area of deductibles, they are not very commonplace either, but they can be bought from some insurers as a way of controlling costs: The general feeling of the public is that they don't like deductibles too much. Maybe they will begin to like them as the insurance premiums increase for not having them.

So what then are the prospects in the U.K. for health care? The National Health Service is going to become more of a funder rather than a provider of care. The private component is going to increase quite rapidly, to be more like the rest of Europe, which may be a tripling in the size of the private sector. There is going to be increasing collaboration between the public and private sectors. The idea being that the National Health Service will become the funding mechanism for most care and that the provider of care could easily be private as well as public. It's a matter of better value for money, greater efficiency in the system so that the money is spent more wisely than perhaps has been in the past. This is going to result in more choice for the patients, who will be regarded as consumers of services, rather than patients. And the money to provide these services will be controlled by the patients and their family doctors and so they are going to let the money follow the patient rather than have things rationed.

With regard to the insurance industry, what is it going to do? There are certainly going to be tax incentives coming in from next year and the emergence of cheaper mass market products to supplement the state services. We are predicting a very major growth over the next five or six years with a lot of competition on products and prices from a fair number of sources, although some of the competition will be from people distributing rather than manufacturing the insurance products. And this means all sorts of opportunities for people coming into the market either as distributors or manufacturers.

Just to summarize, at the moment we are spending about 6% of GNP on health care with the government part being slightly more than 5%. I can't see the government expenditure going up. It's probably going to stay around the 5% level or perhaps slightly more, but the private

component is going to increase. I think the government would like it to increase up to 2%, so what we are going to end up with is spending between 7-8% of GNP on health care, very much in line with the rest of Europe. There is no way that we are ever going to spend 12% of GNP on health care and from what I hear from the rest of you, it is going to be more than 12% in the U.S. in the years to come. I think this is very much a matter of social policy, a matter of how much you really want to spend on health to look after the population of the country.

I think we believe in the U.K., and it is reflected in most of Europe now, that the role of the state is to provide core benefits for everyone free of charge, without cost, without having to show an insurance card if you have an emergency and a way to provide a very good public service in the case of emergencies of any sort. But if it is elective, if you can pick and choose, if you can wait, then you really ought to either live with the government priorities for those non-urgent cases or buy some insurance to supplement what the state will give you free of charge or alternatively just pay for it yourself out of your own pocket rather than buy insurance at all, particularly if you already have an existing medical problem.

In the end, we are going to spend a lot less than you are going to spend and that's true of the whole of Europe. I think the question is, what will you get for the extra money? Will you live longer, will you be happier, will you have peace of mind? I don't know. I know in the U.K. we feel we have peace of mind for having the free National Health Insurance for everyone. Those with the insurance on top of that have peace of mind because they know that they will have more choice. If the state can't provide them, insurance will. And we, I suppose, will be relatively happy once the National Health Service becomes more efficient and productive. I don't know how happy you're going to be. I don't know, as the proportion of GNP that you're spending increases from 12% to perhaps 15 or 20%, whether you will still be as happy as you are now, or whether you'll say enough is enough.

MR. HARTNEDY: I'm sure a number of you have different views of what needs to be done in National Health Care. We haven't raised all the questions though, and I would like to raise just a few more right now that you're going to need to think about.

What is society's obligation towards the health of its citizens who cannot pay for their health care? What about those who can pay, but won't? What responsibility do individuals have to properly care for their own wellness? Should insurance primarily protect only the assets of the individual insured and if so, does this mean that only those with assets have motivation to pay for health insurance? Two increasingly popular solutions to these and other problems are mandated health insurance and universal government insurance. But each of these approaches has its own additional problems and costs that can make them inefficient and burdensome as we have heard. There is no doubt that the government is going to have to solve the problem of the uninsured poor. These people cannot afford health insurance and must depend on the charity of the hospital emergency rooms, who then have raised their rates to the rest of us to pay for their uncollected bills. This cost-shifting tactic is becoming much more difficult for them with the cost-containment efforts of Medicare and the insurance industry.

We, in the industry, have to first try and make health insurance available to as many of the current uninsured poor as financially possible. For example, the elimination of mandated coverage features would allow us to reduce costs, making insurance more affordable to more people. Then we have to address the balance of the uninsured population -- those who can pay for health insurance but choose, for one reason or another, not to. The open market with its profit motivation is, I believe, the best mechanism available for America to provide for the financing of the health care needs of its citizens in an efficient and competitive manner.

Another problem is the prevalence of low deductibles. Among other things, low deductibles have raised the cost of insurance, removed financial incentives for the insured and involved the insurance company in much more than catastrophic care. Yet the current tax system and proposed mandates encourage the employee to seek the lowest possible deductible. Frequently this is economically unsound because the lower deductible may actually cost more than the potential benefits, but the government is interfering with individual economic decisions. The government lacks the motivation and the efficiency that drives the private sector. Rarely have I heard policyholders express doubt about receiving their benefits from the insurance company. But there is considerable skepticism about the future of the Social Security system.

A first step in solving the problem of the uninsured would be for the insurance industry to convince those who are uninsured, by choice, to obtain health insurance. These people have opted to go without coverage for many reasons, including the inability to find a company able to provide coverage at a cost that they can accept. One of the causes of this lack of companies in the marketplace is the withdrawal of many companies due to lack of consistent state rate regulation. Ask companies who have gotten out of this business about refused rate increases, delays, different standards by states, unexpected changes in states procedures. We need to find a way to finance the health care for a significant number of the 37 million people who are uninsured. Many of these people could afford coverage, but there are a lack of suppliers.

To get more suppliers we need consistent rules among the states, so the companies will understand that they are dealing with insurance risks and not regulatory risks. One way to ensure this uniformity would be to allow companies to simply file rate revisions, if they are willing to guarantee a minimum loss ratio. The company could then begin to use the new rates immediately, without specific approval, but still both the customer and the regulator would be assured that there would be a reasonable minimum value for the dollar paid for the coverage because of a minimum guarantee. This guarantee could go so far as to require the company to reduce premiums or improve benefits or even refund the premium in order to meet the minimum loss ratio that they guaranteed. The company would be required to report to the state each year indicating whether it has met the guarantees to provide appropriate dollar return to the customer.

In this uninsured population we are talking about a lot of people who are between jobs or on the lower end of the income scale, a poor persistency market. A minimum lifetime loss ratio discourages companies from entering this market. But if what we did was file our loss ratios, the ones we intend to meet and that a minimum standard would apply only to years three and later, then we would actually encourage companies to approach this market. In this way the insurance industry would be able to approach the market quickly, motivated by the knowledge that this undertaking can be profitable while also meeting the needs of a substantial number of people who can in fact afford the coverage. All of us here, in particular, need to support and, if necessary, advise the AAA Committee that is now in the process of drafting new rate regulations guidelines for health insurance with our input representing the opinions of our industry. The guidelines could reach the National Association of Insurance Commission (NAIC) as a model bill already having substantial support. But most important, each of us would need to support this model regulation in the various states. If we could obtain uniform passage throughout the country, I believe companies again would approach this market. If our industry accomplishes this goal, companies will re-enter the marketplace to meet the needs of the uninsured while still assuring our customers and regulators that we are giving good value for their dollar. The optional availability of file and use health rates with a guaranteed loss ratio would go a long way in solving the problem of the uninsured.

MR. WILLIAM W. KEFFER: Dr. Robbins, you made several references to the relationship between cost increases or specifically, tax increases and job loss. Could you give us poor actuaries a very simple explanation of the methodology for arriving at job loss figures? I think it would be very useful to us.

DR. ROBBINS: What ends up happening is that as you increase taxes on labor, you increase the tax wedge, the difference between gross wages and what workers have to take home. Among economists, and as a result of the supply side revolution of the last ten years or so, it has become accepted that as a worker I supply labor on the basis of what I get to keep, not on the basis of what the gross wage is but what I get to keep plus taxes and other costs to my employer. So as I increase taxes on wages and salaries, what the worker gets to keep goes down and there has to be an adjustment to bring take-home pay back up, which ultimately ends up increasing labor cost overall.

Now the relationship is based on, to get to job loss, an estimate of what's called a Labor Supply Elasticity, if you will, which is the willingness of workers to increase labor supply as their take-home pay increases and the size of the tax increases. I would be glad to send you a copy of our paper on the 1988 and 1990 Social Security payroll tax increases, because we go through a technical formula there and we have an economic model of the U.S. economy where we estimate labor supply elasticity and tax wedges and all these things.

MR. MARK E. LITOW: We are headed in a situation in which people think that the best solution is to get into National Health Insurance (NHI) and have the government spend more money. We're certainly not heading in the direction that you would like to see us and certainly I'd like to see us going, but also people aren't willing to accept rationing, so there is sort of a conflict of ideas. How can we get the message across to the people in this country where at least 75-80% believe we should go to NHI, that we would have a loss of jobs, that we would have a loss of investment power and this really is not the proper solution. How can we change the direction of where we are headed now?

DR. ROBBINS: I believe that it lies in getting a better message across through newspaper articles, through media, through the work that you all do as actuaries. Right now there is, I feel, a total misunderstanding of what insurance is; that the word insurance really means somehow you are going to pay everything for health care, but to have national health insurance means that you don't have to pay anything for health care somehow. I think it has to start at a grass roots level, getting it across to workers and employers, the little part that we can do by putting out studies and trying to talk to reporters and to politicians and hope that people get the message.

MR. JOSEPH A. SIKORA: In the U.S. we're known to the rest of the world as the most litigious society. Thus, medical malpractice has been a contributing factor to the increased cost. Mr. Orros, in Great Britain is this an area that has been considered? I know traditionally, it probably hasn't had that much of an impact in Great Britain whatsoever, but will there be a need for more medical malpractice in Great Britain in the future?

MR. ORROS: Medical malpractice does exist in Great Britain, but it is nowhere near the same sort of problem that you face over here. I think that up until recently the medical malpractice premiums paid by doctors were the same regardless of their specialty. There are moves now to make them more specific on specialty. I saw figures recently stating that as a result of that, the medical malpractice premiums will vary from about 1,000 pounds to about 4,000 pounds depending on specialty, with obstetrics having the highest premium. That's only a tiny fraction of what you are paying and maybe that's your answer, that it is nowhere near the same problem that you've got. It is quite hard to sue doctors who are not getting a fee at all, so the patient has to find the doctors awith funds and that is quite difficult.