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# HOW WILL SOCIETY DELIVER ADEQUATE HEALTH CARE TO ALL?

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Panelists: JOHN A. KRICHBAUM*
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Recorder: WILLIAM C. WELLER

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MR. WILLIAM C. WELLER: We are fortunate to have a very distinguished panel. Mr. W. Paul McCrossan is a partner with Eckler Partners and is the President of the Canadian Institute of Actuaries. Mr. McCrossan, as a member of the Canadian Parliament from 1978-88, was chairman of the Government Health and Welfare Committee. He initiated the latest study of financing MediCare in Canada into the next century. As vice-chairman of the board of a major Toronto hospital, Paul continues to be actively involved in health care. He will give us the background on the development of that system and compare it with the U.S. multiple systems from his point of viewv, north of the border.

Our second panelist is Jim Swenson who, until earlier this year, worked in Oregon as the administrator of the Oregon Insurance Division. Jim has been involved with the Academy and serves on its Board of Directors. He recently joined Blue Cross/Blue Shield of Maryland. Jim will be discussing health care policy and the financing issues from a state perspective. As many of you may know, Oregon is seeking a Medicaid waiver to implement a new format within which health care will be reimbursed.

Our third panelist is John Krichbaum, who is the assistant vice president of policy development and advocacy group for the American Medical Association. He left a Chicago law firm to join the AMA in 1972 and has worked on state legislation as well as long-range planning, and most recently, the development of the AMA's Health Access America proposal.

* Mr. Krichbaum, not a member of the Society, is Assistant Vice President, Policy Development and Advocacy Group of the American Medical Association in Chicago, Illinois.

As can be seen from this introduction, our panel has viewpoints from outside the health insurance industry. There is obviously no simple solution to the health care problems in America.

MR. W. PAUL MCCROSSAN: Canada has a national health care system. As such, most actuaries in Canada do not concern themselves to any great extent with health care issues. It was my privilege to be elected three times to the House of Commons, where I had the opportunity to serve on the House Health and Welfare Committee and to contribute in a small way to the current Canadian health care system.

This session asks the question, does everyone have the right to adequate health care? In Canada, the question is a simple one. The answer is a clear cut, "yes." I suspect the answer is not too different in the United States. What difference there is focuses in on that key word *adequate.*

Actuaries, as we all know, are supposed to "substitute facts for appearances and demonstrations for impressions." As a former politician, let me start then with my impression. U.S. medicine at its best is the best in the world.

That being said, the public opinion of the U.S. health care system is not so charitable. A recent Gallup poll indicates that among Canadians, 91% believe the Canadian health care system is superior, while only 3% favor the U.S. system. More surprising is that among Americans, 43% view the Canadian system as superior, while only 26% favor the U.S. system.

Polls are continually taken in Canada concerning public satisfaction with the Canadian health care system. The polls indicate a very steady (85-90%) public approval rating. On the other hand, a recent poll cited in last month's PBS September *Health Quarterly* cited that 89% of Americans believe that their health care system needs a complete overhaul.

Something that strikes me as a curious difference in attitudes between Canadians and Americans on the right to adequacy of health care is the apparent ideological split that exists in the U.S. Democrats appear to be tentatively raising the issue, but not with any great amount of enthusiasm. Republicans don't seem to be too receptive at all.

In Canada, the first socialist government elected in Saskatchewan introduced universal hospital care. To that extent, the idea of Medicare came ideologically from the left wing. However, this was quickly followed by a Conservative national government introducing national hospital care in 1957. This was because the Conservative philosophy in Canada places considerable emphasis on the preservation of the family unit and traditional values. These values are felt best preserved inside a system that guarantees adequate medical care. In 1966, the Liberal party introduced available national medical care to all Canadians to cover all hospital, physician and dental services.

Various provinces under various political parties have extended the concept to providing free drugs to the disadvantaged and to senior citizens. Some provinces have now issued magnetically coded drug credit cards to their inhabitants, and there

is some experimentation going on with respect to offering Smart Cards, which will contain a medical and drug history on the embedded computer chip.

There are four key requirements in the Canada Health Act. First, there must be public administration of health in all provinces, and it must be done on a nonprofit basis with audits available to the federal government. Second, the coverage must be comprehensive. It must deliver all insured services without any balance billing or user fees. There is, of course, complete freedom for any individual to choose his or her own doctor, dentist, or hospital. Third, the coverage must be universal. Every resident must be insured. Fourth, the coverage must be portable. This means that when an individual moves from one province to another, the former province continues to pay the bill for a transition period and when an individual leaves the country, he or she must be insured outside Canada for at least the level of reimbursement paid in Canada.

In June 1991, the General Accounting Office of the U.S. Congress published an assessment of the Canadian medical care system. The Canadian system was judged a success, and it cited three fundamental reasons for its success. These are the principles of universality, uniform reimbursement, and systemwide spending controls.

In 1971, both the U.S. and Canada spent the same amount on health care -- 7.5% of gross national product (GNP). However, as a result of introducing national medical care, the costs have been much better controlled in Canada. In 1989, costs amounted to 8.9% of GNP in Canada, as opposed to 11.6% of GNP in the U.S. This has enabled Canada to spend $600 less on medical care per capita than the U.S. does, but at the same time provide universal coverage. The U.S., on the other hand, currently has approximately 37 million uninsured residents.

Where are the savings found in Canada? The principal savings come from administration. The administration costs of our system are approximately 80% less than those in the U.S. We also spend 34% less on physician costs and 18% less on hospital expenses.

The substantial savings in administrative cost are obvious. We have no marketing, no billing, no premium collection, no underwriting, and indeed, no actuaries, to speak of, designing policies. We have very limited claim forms filing. Hospitals and physicians do not have to employ an extensive staff for financial recordkeeping.

With respect to physicians, a national system where doctors are guaranteed 100% collections on all services has enabled provincial governments to bargain quite aggressively with the provincial medical associations. This has meant that over the 15-year period (1971-85) in Canada, physicians' incomes rose 18% less than the cost of living; whereas, the comparable U.S. physicians' incomes rose 22% more than the cost of living. There is, in Canada, no legal opportunity currently to have balance billing.

However, while physicians in Canada experience lower gross incomes, their net incomes are not all that different. They do not need to hire a staff to keep track of their financial claims records and collections. They also have much lower legal expenses than their American counterparts. For example, general practitioners in

Canada currently pay annual professional liability premiums of about $645, compared with about $8,900 for their counterparts in the U.S. Across the medical profession, Canadian doctors pay less than one-tenth the amount that their U.S. counterparts pay in professional indemnity costs. In part, this is a result of fewer lawyers in Canada, leading to less litigation and a feeling that contingent fees are unethical. In Canada, the legal profession feels that a lawyer should not have a financial interest in the results of a court case. Another important legal difference, which was pointed out by Vice President Quayle recently, is that the losing side is almost always assessed the legal costs of the winning side. This tends, of course, to deter nuisance suits.

Hospitals are generally funded in Canada on a global basis. Budgets are reviewed annually to determine the types and intensities of treatments, and hospitals' budgets are updated as a result. The hospital has no financial interest in whether it receives payment for a particular case. There is another important difference that I will illustrate later. In Canada, the medical system is directed towards primary care, rather than secondary care, at the hospital level. A third difference is government-imposed limits on hospital high-technology. Hospitals must obtain government approval before purchasing expensive high-tech equipment. For example, among the four hospitals in Northeast Metro Toronto, there is only one magnetic resonance imaging (MRI) unit. There are also limits on purchasing lithotripters. Indeed, there is an emphasis on alternative techniques for removing gallstones, that are felt to be much more cost-effective and just as medically effective.

Notwithstanding the global costs, Canadians make many more visits to physicians per year than Americans do. Indeed, there are more than four times as many general practitioners and family physicians in Canada per capita as there are in the U.S. Fifty-three percent of all physicians in Canada are still general practitioners, while 47% are specialists.

In comparing this difference in emphasis with the U.S., we note fewer physician visits being made by Americans, with only 13% of American physicians being general practitioners or family practitioners. Eighty-seven percent are specialists. For many Americans, the prime source of medical care is a visit to a hospital emergency room. Some 90 million Americans had hospital emergency room treatment in 1990. Recent studies in Chicago have shown that six out of seven emergency room visits are deemed "inappropriate." Presumably, people choose to go to hospitals because they do not have regular access to physicians. This, of course, has led to major financial problems in some U.S. hospitals, with $8.3 billion of unpaid trauma bills in 1990. Nearly one-seventh of the designated trauma care units in the U.S. have closed over the last five years as a result of financial pressures.

What did the General Accounting Office conclude about the relative merits of the Canadian and American medical care systems? Their conclusion is rather startling. If the U.S. were to adopt universality, uniform reimbursement and national spending controls, it could offer national health insurance to all Americans at no additional cost. The GAO estimates that there would be an additional $18 billion of expenditures for covering uninsured Americans and an additional $46 billion as a result of the elimination of deductibles and coinsurance. On the other hand, the GAO said that there would be savings of $34 billion as a result of expenses currently being paid for the private insurance system and a further savings of $33 billion as a result of a reduction

in expenses in hospital and physician recordkeeping overhead. While these numbers conveniently add to a net savings of $3 billion and must be suspect, I do not find the overall conclusion unreasonable.

Now let's substitute some facts for appearances. Canada is roughly the same size as the U.S., but it is much less densely populated. Notwithstanding the large proportion of people in remote areas, life expectancy in Canada is about a year-and-a-half greater than it is in the U.S. Infant mortality in the U.S. is almost 50% higher than it is in Canada. I suspect this is due in large part to the fact that apparently only 76% of Americans receive prenatal care in the first trimester, as opposed to nearly 100% in Canada (see Table 1).

TABLE 1
Life Expectancy

| | Male | Female |
|---|---|---|
| Canada | 73.1 | 79.9 |
| U.S. | 71.3 | 78.3 |
| Infant Mortality | | |
| Canada | 7.3 deaths/1,000 live births | |
| U.S.* | 10.1 deaths/1,000 live births | |

* Only 76% prenatal first trimester care.

As in the U.S., health care costs in Canada are deemed to be rising too rapidly. General health care costs are largely paid from general government revenues. What strategies are being used in Canada today to try and control expenses? First, there is a sustained attack on tobacco usage. This is because our statistics indicated that the single largest preventable cause of illnesses and premature death was tobacco. The federal government and some provincial governments have passed smoke-free workplace legislation. The federal government has legislation phasing out smoking when traveling in common carriers. There are severe restrictions on cigarette advertising and considerable limitations on sponsorship of sports events. However, the main attack being taken by the government has been to dramatically raise the price of tobacco products. A package of cigarettes in Canada now costs nearly twice what the equivalent pack costs in the U.S. In the last three years, we have seen the most rapid decrease in cigarette usage recorded among western countries, as a result of a sustained, deliberate attack.

There was considerable advice given to the Commons Health Committee, that every dollar spent on prenatal care would have a potential payback of $5, in terms of expenses incurred with low-birth-weight babies. More and more attention is being paid to adequate nutrition and prenatal care, to try and avoid the expenses and difficulties associated with these level-two and level-three babies.

Ontario has been actively pioneering intensive treatment for workers' compensation accident victims. More or less along the lines of sports injury treatment centers, they appear to pay off overall.

Certainly Canada is rationing high technology in medicine. For example, the government of Ontario must approve all major technological purchases by hospitals in Ontario and they have severely limited MRI (to 1/7 of what the U.S. has) and lithotripter (to 1/10 of what the U.S. has) acquisitions. Similarly, there is a much slower (1/2 of the U.S.) rate of open heart cardiac catheterizations in Canada compared with the U.S. When these operations take place, they take place in centers where is a high volume of these operations or treatments are done. This means that both the equipment is better utilized than in the U.S., and there are indications of higher success rates of treatment because of more familiarity with procedures.

At the same time, the provinces have begun to unmercifully squeeze hospital budgets. This is going to lead to significant public controversy in Canada over the next year, as the government tries to force hospital managements to become more efficient.

Finally, as you're probably aware, Canada is shifting away from an income and corporate tax base and moving towards consumption taxes. The reasons for doing this are fairly obvious. If we continue to tax our manufacturers, our manufactured goods will be less competitive, and this will discourage exports and encourage imports. Similarly, in a service-centered economy, more of the burden has to be passed over to the service sector. The government, in line with all other Organization for Economic Cooperation and Development (OECD) countries, other than the U.S. and Australia, has moved to a multistage consumption tax, which effectively passes some of the costs of running government over to goods imported into the country.

What are the outstanding problems in Canadian Medicare? The first problem might not seem like a problem. We feel we have too many physicians. In Canada, it seems that every physician added also generates additional work. Physicians will generate work to achieve the incomes they expect. Obviously, to a certain point, additional check-ups and procedures are beneficial, but many observers feel we have passed that point. The government is actively restricting immigration of doctors and the number of doctors graduating from Canadian universities.

Second, the government has no concrete plans for dealing with the dramatic costs that will inevitably occur as a result of the shifting demographic scene. The costs of treating the elderly can be three to five times those of treating the active, working population. However, it is difficult to get policymakers to focus on changes that will not take effect for another 15 or 20 years.

One problem that has become apparent is that, as a result of the free drug plans, Ontario in particular has, I believe, the highest drug usage per capita in any jurisdiction. A major cause of hospital admissions of senior citizens is adverse drug interreactions. One way to control this may be Smart Card technology, where people are issued cards that contain their medical and prescription histories, to be shown at the time they receive prescriptions. This will no doubt substantially increase medical treatment's efficiency, but it will also raise severe privacy-of-information problems.

We also find that a significant number of active treatment beds are being taken up with the chronically ill, and we do not have an appropriate solution to this increasing problem.

In my opinion, Canadian hospitals do not have the databases to analyze how best to control hospital usage. I find that the U.S. is far more advanced in procedures to ensure the best medical treatment in hospitals. Our strength is low administration costs. Our weakness is poor data.

Over the next decade, I expect the medical ethics debate in Canada on "heroic" treatments to grow. We are increasingly spending a substantial portion of our medical care dollar on prolonging life, rather than restoring health. The U.S. is much further along in the concept of a living will. In Canada, in many instances, doctors feel themselves ethically committed to prolonging life, even for very short periods, in terminal situations.

Notwithstanding our national commitment to adequate healthcare, it is evident that we are not succeeding in delivering it to our aboriginal population. Whether the problem is remoteness or sociological is questionable.

Finally, while Canadians are proud of their healthcare system, they detest the shift to consumption taxes. Those same residents of border cities, who would not move to the U.S. because of lack of Medicare, increasingly shop in the U.S. to avoid high taxes that support it.

In summary, Canadians believe a national healthcare system is the only way to ensure adequate medical services. Overall, we are delivering superior services at a reasonable cost, although there are some failures. Our success may be based on greater access to primary care. Medicare is financed through general tax revenues. Cost containment is a major issue, and we have effectively gone to a user-pay system for smokers. Public resentment of taxes needed to support our system is increasing, when compared to lower U.S. taxes.

MR. JAMES R. SWENSON: I predict issues of access to healthcare are likely to be major areas of U.S. legislative activity during the 1990s, both at the federal and state levels. However, the most innovative action is likely to occur at the state level for the next several years.

The federal government has no funds to facilitate any significant initiatives. In addition, there is no consensus at the federal level. However, it is quite likely that the U.S. Congress will work around the edges of the access problem. For example, it may enact small group reform legislation if the states fail to move rapidly enough.

As this audience knows, the U.S. has always had a significant share of its population lacking health insurance. A legitimate question to ask is why the states are now taking action to address the access problem. Today, I plan to answer this question and describe the steps my former employer, the state of Oregon, is taking to address the problem.

Approximately 400,000 Oregonians lack health insurance. This is comparable to other states and represents their proportionate share of the U.S. uninsured population.

State policymakers agreed that the problem of access was growing and had to be addressed. Traditionally, services to the uninsured were provided by fee-for-service

providers who merely shifted costs to other payers. However, it was becoming increasingly difficult to shift costs for several reasons. First, the number of uninsured was growing, despite a strong economy during the 1980s because: (a) healthcare costs exploded, causing some employers to drop coverage, particularly for dependents; (b) the state was shifting from a manufacturing economy, with a high proportion of health insurance, to a service economy; and (c) one-parent families were becoming more prevalent.

Second, the U.S. government was shifting enormous costs from the programs that it funded. When Medicare diagnostic related groups (DRGs) were first implemented, the rate of reimbursement was quite fair and, in fact, if a hospital was astute and was able to save a few dollars through efficiency, it actually made money with the DRGs that were initially provided. However, in order to meet Gramm-Rudman-Hollings targets, the DRG level of reimbursement has been rising at a much more gradual rate. This has, in effect, helped to exacerbate the problem of health care cost. I think it was in part responsible for the severity of the last underwriting cycle.

Finally, the success of managed care was placing more pressure on providers. The evolution and further development of managed care alternatives has actually helped to exacerbate the problems of access to health care in those areas where some of the managed care alternatives are of a closed system environment. For example, the city of Portland is very privileged to have an excellent Kaiser Permanente plan, which covers approximately 25-30% of the residents of the Portland area. Since the Kaiser Permanente system is closed for all intents and purposes to those persons who lack health insurance, the remaining 70% of the people and the providers delivering services to those 70% were required to pay indirectly through the cost shift for a much larger percentage of the uninsured population than would have otherwise been required, given the economics of the state.

Oregon legislators enacted several bills to address the problem of the uninsured. I would characterize this legislation as a public-private partnership.

One bill created and funded a risk pool for uninsurable Oregonians. Approximately 25 states now have such high-risk pools. Another 10 or 15 states, primarily Eastern states, have open-enrollment periods, during which time uninsurables are able to obtain coverage. It is, therefore, possible for people who lack health insurance or who are uninsurable to be able to access some form of health insurance, albeit expensive, in most states in the U.S.

A second bill expanded a program designed to encourage small employers to voluntarily purchase insurance. The majority of the uninsured are employed by small employers or are dependents of the employees. There were two primary incentives to encourage the employer to purchase health insurance under this program. The first incentive was a state tax credit equal to $25 per month per employee. To be eligible, an employer had to employ 25 or fewer employees and not have contributed to the employees' health insurance coverage during the past two years. The second incentive was a waiver of normally mandated benefit requirements, thereby permitting a less expensive health insurance program.

Qualifying insurance packages are currently being marketed by several companies. Approximately 15,000 persons are now covered under these programs, making this one of the most successful small employer programs in the country. However, a large number of small employers lack coverage and the program is a long way from its target to insure 150,000 people.

If this voluntary program is not successful in providing protection to virtually all of the potential employers by the end of 1993, a mandate becomes applicable. The mandate is a "play or pay" program, similar to that enacted in Massachusetts.

To facilitate the current voluntary program, small group reform legislation was enacted this past year. The reforms were modeled after the evolving NAIC reforms and include both rate restrictions and a requirement to guarantee insurability. The latter requirement is facilitated by a voluntary, prospective reinsurance mechanism.

The rate reforms are more restrictive than the NAIC reforms, reflecting Oregon's political environment where there was strong pressure for a pure community rate. The reform requires insurers to select an average community rate for each product and to then operate within a rate band that is +33% from that average community rate. All rating variables, demographics, industry, health status, claims experience and duration must operate within the band.

The final bill, which I would characterize as landmark legislation, has been referred to as Oregon's rationing program. This bill authorizes the prioritization of services to be covered by Medicaid, to permit an expansion of that program to all Oregonians whose income falls below the federal poverty level.

The primary sponsor of this legislation was state senate president John Kitzhaber. He is an extremely thoughtful and ethical gentleman who is also an emergency room physician. He recognized that there were a large number of uninsured with very low incomes who did not qualify for Medicaid. In order to be eligible in Oregon, a person had to have income less than approximately 60% of the federal poverty level. That is not untypical, and some states have income thresholds as low as 25% of the federal poverty level.

However, as a state senate president, he was not a single issue legislator. He recognized that the resources of the state were limited and that there were many other programs worthy of funding, such as education and crime prevention. He concluded that Oregon was already rationing health care through low-income eligibility thresholds. He believed there was a more responsible and equitable way to ration care, namely through rationally prioritized care.

It was concluded that services to be covered by Medicaid should be ranked in order of priority, and that coverage should be extended to all Oregonians whose incomes fell below the federal poverty level -- adding more than 100,000 people to the program. To help free up funds to accomplish this task, lower priority services would not be covered. In essence, rather than providing Cadillacs to a few, the state would provide Chevies to many.

Senator Kitzhaber made this proposal his number one priority and convinced his colleagues to pass the landmark legislation in 1989. The law created a Health Services Commission. Its mandate was to "report to the governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population served."

The cost of those services, in a managed care environment, was to be determined by an actuary under contract. Each service was to be priced separately, assuming all those with incomes below the federal poverty level were eligible.

The legislative assembly was then required to make the difficult decision. Using the priority ranking, associated costs, and given the fact that all persons with incomes below the federal poverty level were to be covered, they had to determine how much revenue could be allocated. That determination, combined with the cost and rankings, dictated where the line was drawn for services to be covered -- those services falling below the line would not be covered.

Implementation of this program requires a waiver from the Health Care Finance Administration (HCFA) to permit normally mandated benefit requirements to be waived. The state is now seeking the waiver, but the politics are proving to be a challenge.

The Health Services Commission spent a year-and-a-half developing its prioritized list of services. Many hearings were held to elicit the public's views. The public was asked what services were most highly valued. Medical experts and medical ethicists were also consulted.

Initially, the Commission developed a formula to rank more than 700 condition and treatment pairs. The formula considered three factors:

1. What was the cost of the treatment?
2. What improvement would there be in the person's quality of life after receiving that treatment?
3. How many years would the improvement last?

The initial results of this formula-driven approach were disappointing to the Commission. There were problems with the quality of the input data. In addition, the results were not fully reflective of the members' intuitive judgments.

The Commission began to correct the input data. It also developed an approach where each of the more than 700 condition/treatment pairs were grouped into a major category. There were 17 major categories and these categories were also ranked in priority order.

The top-ranked category included conditions and treatments that were acute and fatal, where treatment would prevent death and result in full recovery. An example would be an appendectomy.

The second-ranked category was for maternity care, including the care of the newborn for the first 28 days of life.

The last, or 17th-ranked category, included conditions that were fatal and nonfatal, but treatment would provide only minimal or no improvement in the quality of well-being. An example would be medical therapy for viral warts.

This new approach, combined with the prior formula-driven approach with improved data, permitted the Commission to complete its ranking and produce a list that ranked approximately 710 procedures from number 1 all the way down to number 710.

During the 1991 Assembly, the legislators made the difficult funding decision. Since they were adding more than 100,000 people to the rolls, they found it necessary to allocate additional funds for Medicaid to avoid Draconian cuts in service. If they merely tried to eliminate procedures to free up enough money to add about 120,000 people to the rolls, the line would have been drawn at a level that was significantly higher than where it was actually drawn. They increased funding for Medicaid by about 10% and were able to draw the line at roughly the 580th procedure.

The state is currently in the process of developing an implementation program and is seeking the HCFA waiver. The private health insurance industry has also been challenged to develop a basic health plan that would be compatible with the benefits to be provided under the new Medicaid program.

The basic plan that it develops will become the basis for the voluntary small-employer program. Ultimately, I predict the basic plan it develops will replace other mandated benefit requirements.

It should be noted that the state of Oregon is a fairly liberal state. The legislators do not want the Medicaid program to be perceived as a program suitable only for low-income people. They want the program that they would be funding to be perceived as being adequate for all Oregonians. They were really trying to define a basic plan in this process.

It will be interesting to observe Oregon's progress. I sincerely hope the federal government permits the state the opportunity to implement the program, and I wish it every success.

MR. JOHN A. KRICHBAUM: Before describing the AMA proposal for health care reform, I would like to comment briefly on the presentations of the two previous speakers.

In regard to the Canadian health care system, I think I could summarize the AMA position as saying that there is much to commend in the system. We simply believe, and we think that there is a growing consensus in Congress that shares this view, that it is not the system to transplant to the U.S.

We would also take note that recent studies, including the August 28, 1991 issue of *The Washington Post* documenting one study, indicate that at least a good portion of the extra health care costs in the U.S. cannot be attributed to administrative cost or overtly lavish care and really are not a fault of the system. Although, as I will mention in a few moments, clearly the U.S. health care system needs fixing.

Let me just mention a few of the examples noted in *The Washington Post* article that demonstrate some of the social problems that add to the total medical costs in the U.S., and how they are different from Canada and other countries.

The U.S. male homicide rate is four times that of Canada, and there are as many as 100 assaults reported by emergency rooms in the U.S. for every homicide. The U.S. has about four times the number of AIDS cases, based on population, as in Canada. We have an enormously higher proportion of drug-exposed babies in the U.S., at an annual medical cost of about $500 million per year. Our teen fertility rate in the U.S. is twice that of Canada's.

The methodology, the political motivation, and a number of the assumptions of the GAO study are subject to criticism. For example, a significant portion of the greater U.S. physician administrative costs were attributed in the report to nonphysician salaries and benefits in the physician's office. This clearly overestimates its part in the physician administrative costs, since nonphysician salaries and benefits include spending on technical personnel who have nothing to do with billing or clerical work.

A brief comment on the Oregon plan is that the AMA has been strongly supportive of the granting of the waiver. The AMA has not supported the substantive rationing of care argument in the Oregon proposal. But we think that it is worthwhile for state experimentation to grant Oregon the waiver.

Now, let me mention the AMA's position on the patient's right to health care. Every patient does have a basic right to available, adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. The fulfillment of the right, however, is dependent upon society providing the resources, so that no patient is deprived of necessary care because of an inability to pay for that care.

Let me cover with you some of the basic assumptions and principles that the AMA used when it drew up its Health Access America Reform proposal. Copies of this proposal are available.

The first assumption is that the U.S. must have universal access to health care. Second, the free market is generally preferable to government control, but clearly, government has a major role to play. Third, it is better to control costs through incentives that give all parties a share of responsibility, rather than by government fiat. Finally, we must increase the availability of affordable insurance, particularly to small business.

At its best, as was noted by the first speaker, health care in the U.S. is unsurpassed. Our medical education system is superb and produces highly trained physicians. Our centers of excellence have a global patient base. Some 213 million, or 87% of all Americans, have health insurance coverage. However, it is clearly unacceptable that somewhere between 33 and 37 million Americans have no insurance. It is a disgrace to our country.

Clearly the health care system in the U.S. needs fixing, as I stated before. But we believe that there is a growing consensus in the Congress that this reform must be incremental and that we should not -- and we cannot -- build that political will to

enact health care legislation to cover those who are now uninsured by jeopardizing the health care and the quality of care that is available to 87% of Americans. We believe that in a time of burgeoning debt, the federal government should not call for replacing the private health care system with a government-controlled system.

The federal government now spends more money to pay interest on the national debt than it does on health care. The rate of increase in payment of interest on the national debt is greater than the rate of increase and cost of health care, national defense, social security and other major programs.

Let me abbreviate some of the other remarks and just note for you that some of the things that have happened in the last year or two and some of the statements of leading politicians in the U.S. that, we believe, underscore the validity of an incremental approach to health care reform.

At the end of the last Congress, there was an expansion of Medicaid coverage for pregnant women and children. Second, there was a decision earlier in the year by the AFL-CIO to push for incremental health reform, rather than a national health insurance proposal. Senators Mitchell and Bentsen and Representative Dan Rostenkowski, plus others, are now proposing incremental reform as the most achievable way of obtaining health care reform.

Let me outline the basic proposal of the AMA for health care reform. First of all, we think there needs to be substantial Medicaid modification to provide uniform benefits to all persons below the poverty level, without the categorical eligibility factors that now complicate and hamstring that program. Currently, Medicaid covers only about 42% of those below poverty.

Second, the AMA believes that there ought to be a required mandate on all employers to provide health insurance for full-time employees and their families. This is very important since about 28 million of the 33 million uninsured are employed or dependents of employed persons.

We are, of course, aware of the potential impact of this required insurance, particularly on small employers, and clearly note that there would have to be a phase-in with appropriate tax incentives. It is also worth noting that, while much of the focus is usually on small employers, about 50% of the workers and dependents who are uninsured are indeed in firms of 25 or fewer. The other 50% of workers and dependents who are uninsured are in firms of over 25. Thus, even though a phase-in might first go to the very large employers, it clearly can have a beneficial effect.

One of the areas of health care reform receiving quite a deal of attention at the moment is small market insurance reform. It is our opinion that there ought to be: (a) community rating across all small groups, (b) no preexisting condition restrictions, (c) guaranteed acceptance, possibly through an assigned risk pool, (d) guaranteed renewability with limits on premiums, and (e) carriers offering a basic benefits policy.

Health insurance market reform is particularly attractive to legislators because so much can be done without government expenditures.

Another significant aspect of our reform proposal is the creation of state risk pools to make coverage available for the medically uninsurable. We note that if these state risk pools are going to be more effective than they have been in the past, there clearly has to be a broader basis for underwriting the excess cost of those pools. That would have to be brought about through either an amendment to the federal tax code or an amendment to ERISA to bring about broader based support for those excess costs.

Medicaid reform is another part of the AMA proposal. Some method must be found to secure the financing of this program. I think all of you know how much trouble that program is in. Medicaid funding of long-term care and for those below the poverty level is an essential part of our program. An asset protection program using the private insurance system for those above the poverty level is another.

Professional liability reform is an essential element of the AMA proposal. You have already heard the rather startling distinctions between the cost in Canada and the U.S.

The development of professional practice parameters to help ensure that only high-quality, appropriate medical services are provided is a key element of the AMA proposal.

We also suggest altering the tax treatment of employee health care benefits to reduce the incentives toward first-dollar coverage. Specifically, we would support placing a limit on the amount of employer-provided health insurance that is tax-exempt.

Health promotion and disease prevention are important elements of an overall comprehensive reform proposal, as is reduction of administrative costs. Clearly, we have too many administration costs in the U.S. But we happen to think that some of the studies that show the administrative cost differences between the U.S. and Canadian systems need a lot more attention and are somewhat suspect in their overarching conclusions.

We would like to see the system that existed years ago be allowed again, whereby patients could come to local medical societies if they wished to complain about fees. That way, patients would have a place to go, rather than having to file a lawsuit as the first step.

The American system has serious problems, along with great strengths that serve most of the people in the U.S. very well. We need to set priorities. We need to have a legislative agenda that tries to enact achievable results, rather than just speak in terms of comprehensive global changes that probably will never be brought about in the U.S.

We need to fill the gaps. It will take more money. It will probably take an increase in taxes, but we need to move on and get those things accomplished.

MR. JOSEPH W. MORAN: Mr. Krichbaum, the AMA proposal does not seem to be addressing directly this general problem of the metastasizing health care delivery system in terms of the GNP. What specifically do you visualize as the mechanisms for constraining the increasing growth in the delivery system as being part of your

package? Does it involve a reduction in the number of doctors or a reduction in the compensation earned by doctors? Or is it all supposed to come from fringe costs?

MR. KRICHBAUM: Well, clearly it is not supposed to all come from fringe costs. I think that when you hear about the differences in the professional liability costs between the U.S. and Canada, it points to the great need in the U.S. for liability reform. That can lower the cost of defensive medicine; not just the doctors' premiums, but the overall cost of the system. If we can develop professional practice parameters so that physicians can, in fact, deliver the highest quality and most appropriate care, that can help to lower cost. It is always less expensive to provide the best care first, rather than later.

There are a number of things that we think the free market can do, if people are given a greater incentive to talk about costs with their physicians. We think doctors ought to have to tell people about their charges and maybe post their most common charges. People can then become more informed consumers and can question costs. We do not happen to believe that administration by the federal government, either by setting a global budget or otherwise, would bring about more efficiency or quality in the system.

MR. MORAN: So you don't see a specific target as to reducing the share of GNP?

MR. KRICHBAUM: I do not believe, and the AMA does not believe, that an arbitrary figure of the GNP should be set. I do not think that the American public has ever said that it would like a cap put on the amount of GNP spent. In fact, most of the surveys have indicated that Americans are willing to pay more. They would like to make sure that they are getting value for that money. They do not want it wasted either by physicians being overpaid or through inappropriate care or administrative waste; but they never indicated in surveys that they would like to see an arbitrary limit placed on the expenses.

MR. SANFORD B. HERMAN: My question involves three areas that we see as rising proportions of medical care. First, how are mental, nervous, alcohol and drug abuse handled in Canada versus the U.S? The second is the issue of prescription drugs. The AMA proposal would not cover prescription drugs, and I am not quite sure how that is addressed in terms of an AIDS patient whose choice is azidothymidine (AZT), or going into the hospital for expensive treatment. The third area is diagnostic medicine. I do not see where the AMA is talking about any reforms related to physicians who own their own laboratories and diagnostic equipment, where there appears to be a certain degree of self-dealing. I would like a comment from whomever wants to respond to these issues.

MR. MCCROSSAN: Well, with respect to mental, nervous, alcohol and drug abuse, which was your first question, my sense is that treatment of mental and nervous illnesses is fairly comparable to the U.S. Our treatment of drug and alcoholic-related illnesses is inferior. There is a substantially lower frequency of drug abuse. The problem has emerged more recently, and is less prevalent; but certainly we have responded quite inadequately, I think, to the problem of drug or substance abuse in general. With respect to the conflict of interest in the diagnostic laboratories, I think that it is a medical ethics problem. My understanding is that it is viewed as a conflict

of interest in Canada, but there are ways around that through the back door. These exceptions are even being pursued by the medical profession here because of the feeling that there is a direct conflict of interest if you benefit from the treatments that you are prescribe.

MR. KRICHBAUM: I might just comment briefly on a couple of those aspects. In this minimum benefits package that the AMA recommends for the required employer insurance as being the essential package of benefits, there is a limit of 20 office visits per person per year, and 45 inpatient days per person per year. When we worked with The Wyatt Company in Chicago on the cost of this proposal, we had problems within our own association of not unfairly placing restrictions on specific types of care, be they psychiatric or alcohol or drug abuse, but clearly we also recognized that in order to keep the cost of the package within reason (in wanting it, in fact, to be a basic benefits package), these types of limits were necessary. We think people will recognize where those limitations have the most impact relative to your question.

MR. WELLER: Jim, what about Oregon? Did it treat these specifically in the 17 categories or merge them in?

MR. SWENSON: The issue of drug, alcohol, mental and nervous condition treatments is one that has been finessed for the moment, if you will. They will try to merge those treatments with the other 710 treatments. At present, that merger has not taken place. There is a separate panel that has been doing work on that issue.

I would like to make another comment about professional liability. Former Governor Lamm of Colorado was reported as saying, "The U.S., with 5% of the world population, has two-thirds of the world's attorneys, but you can't sue your way to greatness." I think that is a very apt description of part of our problem. Having been a regulator who was responsible for regulating commercial liability product lines as well, I know that it is a major issue.

The Oregon program, does provide a safe harbor within the legislation for those practitioners who do not provide one of the services that is not funded by Medicaid. If service number 650, which is not being funded, was not provided, and a suit was brought against that practitioner for not providing that particular service at the state level, there is some protection in the law. Only the courts will tell whether or not that protection is meaningful, but it is certainly the intention of the legislators that there be protection against professional liability litigation in that situation.

MR. KRICHBAUM: Just a very brief, additional comment on the issue of referrals. The AMA position has been a very strong one over the years, with ethical guidelines against referral for the self-interest of the physician. The AMA position is very clear: physicians who do that ought to be subject not only to medical discipline but to criminal penalties as they apply.

There have been many provisions in legislation, through OBRA 1989, that addressed this. A number of these provisions are relatively new and have not had a chance to have an impact. We ought to give that legislation an opportunity to see how it works before we enact additional legislation. Clearly, if a physician is referring for self-interest, that physician ought to be subject to discipline, license revocation or

restriction, and criminal penalties. The AMA has, within the last month, also formed an advisory panel with outside consultants, including Newton Minnow and others to come up with any additional guidelines that might be needed in this area.

MR. JOHN P. BURKE: Mr. McCrossan, should the government as the financier of health care be making individual and societal right-versus-wrong decisions based on the cost of health care (e.g., smoking costs)?

Second, the statistics that you stated for the growth of health care in the U.S. and Canada were in terms of a percentage of the GNP. I have seen statistics that indicate the U.S. GNP has grown slower than most of the countries that we are often compared with for health insurance or health costs overall.

In Connecticut, there is a small group reform bill that seems to address a lot of the issues that the Oregon legislation has as well. It is less onerous in the rating provisions. Not a lot of people have signed up for the basic plans, and I contend that the issue is one of affordability, not uninsurability. With the narrow limits in Oregon, health insurance will only become more expensive.

Mr. Krichbaum, the AMA proposal seems to be so self-serving as to not engender a dialogue. There should be some give by all parties. I did not see anything in what you discussed in the AMA proposal that seemed to be relinquishing anything from the medical profession's position.

Community rating, guaranteed issue, and no preexisting conditions is pretty onerous for insurers; it does nothing for the cost of medical care, but cost of insurance will be higher. That would increase the number of uncovered individuals in the U.S. populations.

MR. KRICHBAUM: I think you made an excellent point when you said the GNP in the U.S. has not been expanding at the rate that it had in prior years, and therefore, the percentage going to health care was larger. I think that is accurate. Maybe there ought to be some defined limit, but if anyone knows what that is and what limit would be acceptable to the population in the U.S., because we do not know.

In regard to physicians contributing, I think one of the elements within the proposal that would bring about, in fact, a contribution by physicians, is the proposed part that deals with less insurance coverage for first-dollar-type activities. When there is less first-dollar coverage, there is going to be more bad debt and less payment going to physicians. That is one of the elements that is going to have a practical effect on physicians. When physicians have to follow practice parameters developed by professional organizations, there is going to be a limitation on the clinical autonomy. A number of physicians have complained about the AMA's position in support of development of practice parameters. All physicians think they know what the best answer is, they do not like to be told that they have not done something or that they have done too much. The development of practice parameters places a limitation on some of the things that physicians can do, but for the best interest of the patients.

MR. MCCROSSAN: You raised a number of interesting points. Maybe I can answer a couple of them in detail and a couple philosophically.

I do have the statistics per capita. I used the numbers as a percentage of GNP because it is the normal UN measure. The changes in GNP in Canada and the U.S. have not been dissimilar over the period I was talking about.

On government as financier, there is an important difference between the collective approach to medicine or to rights in Canada, as opposed to the individual approach in the U.S. That is a fundamental societal difference between Canada and the U.S. The U.S. Constitution starts with a focus on individual liberty with life, liberty and the pursuit of happiness being the objective. In Canada, the objective of the Constitution is peace, order and good government. These are very different, and there is a considerable difference in the collectivism in society that reflects through in different ways. For example, some of the things that are cited in *The Washington Post* article are AIDS, enormously higher drug costs, and teen fertility rates. There is a question of cause and effect. In Canada, we devote a substantial amount of money to all of those programs as part of our health care. We have needle-exchange programs for intravenous drug users, to limit the spread of AIDS. We promote the use of condoms. That is part of the approach of the Department of Health towards the collective responsibilities of government. Some of these things that are cited by the AMA as extraneous factors that increase health costs, I would argue, are part of the basic health care system that have to be addressed societally as well.

I would like to commend the AMA on another point though: the approach towards incrementalism. It is difficult to bring in a system like we have, which has evolved over 35 years. To bring in any sort of comprehensive system, you have to start crawling before you walk, before you run, and it is a matter of targeting what areas you want to attack. In Canada in the 1970s, the major poverty problem was the unattached elderly. Today, it is single-parent families and particularly young children. I would argue that if you are going to start somewhere, the health care that you give the young, urban poor or even suburban young is the place to start incrementally. I am not sure about a cut-off rate at the poverty line. I would argue that all of the young should be targeted for getting adequate health care. It will pay for itself many times over. But you have to start somewhere. Start there.

A point that I did not raise in my prepared remarks is that Medicare in Canada started with compulsory coverage in the employed sector on a premium-paying basis. The government retained all of the insurers and compensated them for claims adjudication for some years. Ultimately, when they nationalized the payment function, they paid the insurers to take over the system.

MR. PHILIP J. LEHPAMER: My employers recently commissioned Louis Harris and Associates to conduct a survey of more than 2,000 leaders: physician leaders, hospital CEOs, health insurers, large and small employers, union leaders, federal legislators, including top committee staff, regulators, and state health care officials. We hope the results of this survey, once widely known, can serve as a basis for building an improved health care system.