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When a man walks into your office, sits down in front of your desk, and tells you that he is Napoleon Bonaparte, do not get drawn into a discussion of cavalry tactics at the battle of Austerlitz (attributed to Robert Solow).

The past three years have seen an extraordinary leap in American interest in the Canadian health care system. Why this sudden explosion of interest? We interpret the process as follows: First, the U.S. system is uniquely unsatisfactory and is continuing to deteriorate in objective, easily observable terms. The broad outlines of this situation are well known to the readers of Health Affairs—increasing numbers of un- and underinsured, uncontrollable cost escalation, failure of the “competitive” strategies of the 1980s, increasing third-party intrusion into the practice of medicine, growing documentation of excessive and inappropriate medical care, and rapid growth of the already large “overhead” costs of an unproductive private-sector health bureaucracy. To quote Alain Enthoven: “It would be, quite frankly, ridiculous . . . to suggest that we have achieved a satisfactory system that our European friends would be wise to emulate”—or Arnold Relman: “Our health-care system is inequitable, inefficient, and too expensive.”

Second, as the saying goes, “You cannot fool all of the people all of the time,” and Americans are becoming increasingly aware of their predicament. Their satisfaction with their system was the lowest among ten Western nations in a recent Harris poll. After an analysis of a wide range of polling data, Robert Blendon and Jennifer Edwards recently concluded that “citizens of this country have decided that fundamental change in our health care system is needed.” More significant for the debate over Canada, however, is the fact that a substantial majority of Americans have repeatedly indicated that they would favor a national health insurance plan financed through taxation.

Third, the traditional alliance between private insurers and physicians

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is threatening to crumble. The ever-increasing pressure to contain costs, although as yet wholly unsuccessful, is bearing more and more heavily on physicians. They find their clinical judgement questioned and constrained by their traditional friends, as insurers are forced to shift from underwriting to “managed care.” Physicians also notice that a rapidly increasing share of health care costs is going not to themselves or even to clinical care but to the administrators of the payment process. The widely noted calculation that the excessive overhead cost of U.S. private insurance is large enough to pay for all the care of the uninsured implicitly suggests the possibility of transferring tens of billions of dollars of income from administrators to clinicians. Suddenly, a public system—preferably with little or no decrease in total expenditures, just a transfer from “unproductive” to “productive” activities and people—seems quite interesting. Thus we find physicians at the forefront of those calculating the costs of private insurance and even suggesting—seriously and with plausible arguments—the outright abolition of the private insurance industry. The American Medical Association (AMA) is holding firm for the moment, but the American College of Physicians has broken ranks and called for a national health plan.

Health Reform: The Reluctant Political Agenda

The extent of support for national health insurance is finally forcing the issue onto a reluctant political agenda. Humphrey Taylor and Uwe Reinhardt recently concluded that the United States is the only developed society without some form of universal coverage because of the peculiarities of its political structure, not the values of its citizens. But even that structure seems finally to be bending under the weight of public concern. Harris Wofford’s Senate victory in Pennsylvania in fall 1991 suggests that Republicans are vulnerable on this issue, and George Bush has come out swinging.

Yet as Blendon and Edwards note, while most of the American public seems convinced that the status quo is no longer tenable, “they are immobilized by their disagreement over the form such changes should take.” It follows that defenders of and beneficiaries from the status quo need not waste time defending the indefensible. They need only concentrate on attacking each serious alternative, while floating endless variations on the status quo. Since Canada is at present a leading alternative, Canada must be attacked and discredited.

The reasons for this spirited response are quite transparent. The U.S. health care system is unquestionably the most expensive in the world, and every dollar of that expense is a dollar of someone’s income. A more efficient system would do away with tens of billions of dollars of sales and
incomes in the present insurance bureaucracy. A system that controlled
the escalation of physicians’ fees and reduced the volume of ineffective
and inappropriate procedures would in the same motion reduce the
incomes of providers and the market opportunities of drug and equip-
ment manufacturers and marketers. The one is not merely a conse-
quence of the other; cost control and income control are different labels
for the same act. Furthermore, these threatened incomes are highly
concentrated. They have their advocates in the associations repre-
senting insurers, physicians, and drug manufacturers, among others.
While the members of these groups are vastly outnumbered by the
millions of Americans who yearn for fundamental reform (and national
health insurance), the latter are relatively unorganized and have (at
least until recently) had no effective lobby and no means of raising the
funds necessary for such activity. It is a classic case of diffuse benefits,
concentrated losses, and there is the very real possibility that the “out-
come” may be dictated not by the merits of the argument but by the
depth of the purse, in the same way that one might “win” a legal case by
exhausting the resources of one’s opponent.

Who, then, should respond to these concentrated interests who are
scurrying to discredit the Canadian system? To a limited extent, Canadi-
ans should, if only to try to set the record straight. But Americans
outnumber Canadians ten to one. So even if there were equal interest in
the American quandary on both sides of the border, sources of Canadian
response would be swamped. But the interest is not equal; Canadians
have no stake in “selling the Canadian system” to Americans. There
are no royalties to be earned by Canadian physicians, analysts, or govern-
ments if the United States should adopt a national health insurance
plan. (The Americans would be free riders.) So the powerful economic
motives behind the attacks on Canada have no defensive counterpart.

Furthermore, we Canadians have problems of our own. The American
newspaper headlines discovering that the Canadian health care system
is not perfect are no news to Canadians. Indeed, some who might
otherwise provide a more balanced view for American audiences are
heavily involved in efforts to understand and improve their own system.
Fortunately, one of the by-products of the explosion in American inter-
est in Canadian health care has been a rapid growth of serious compara-
tive scholarship among the U.S. research community, in part responding
to a heightened interest among American research funding agencies. Of
particular importance, these studies are increasingly focusing on differ-
ences in the health outcomes achieved in the two systems. But this
emerging evidence has not carried much weight in the current Ameri-
can political debate—indeed, it cannot, because that debate has little or
nothing to do with cross-border learning. It is about the defense of
political and economic interests. And these interests are able and motivated to support a thousand points of darkness for every candle lit by the serious research community. The gross misrepresentation of the findings of Leslie Roos and colleagues on postsurgical mortality in the recent Bush health strategy document is a leading example.\textsuperscript{10}

Comparative information on different health care systems is difficult for the public to judge. And while incentives to produce distortion and nonsense are high, the cost of doing so is low. Furthermore, its producers adopt various strategies to convey an aura of “scientific” legitimacy to their messages. In this they are following a trail blazed long ago by marketers of pharmaceuticals, who have mastered the art of presenting advertising information as if it were scientific communications.\textsuperscript{11}

Correspondingly, there will continue to be an oversupply of nonsense. It would be futile, particularly for Canadians, to try to deal with all of it in detail. But there is a deeper problem than the sheer imbalance of resources and incentives. As we and others perceive them, many American commentaries on “the Canadian experience” are in fact discussions of an imaginary Canada that resembles in name only the reality in which we live. These commentaries bring with them images of what a priori “must be,” to substitute for what we believe “is.” At the same time, they compare this “Canada of the (American) mind” with a U.S. system as it is, or more often as they allege it might be, which again seems to us to bear little relation to our perception of the American reality.

“[T]he stage is set, not merely for an unfruitful dialogue, but for a dialogue of the deaf.” In what follows, we identify the ways in which the major discrepancies between this “Canada of the mind” and the reality we and most other Canadians perceive are rooted, as A.J. Culyer states, in “fundamental differences in perception and observation . . . of how many of the key actors in any health system operate, what their aspirations are, and how constrained they are in achieving them.”\textsuperscript{12}

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**Differences Of Perception**

**Market faith.** Recent contributions to *Health Affairs* provide examples of such “fundamental differences,” Jacques Krasny and Ian Ferrier assert that “it is unnecessary to prove that a market environment that provides abundant and varied resources . . . is inherently better than one that does not.”\textsuperscript{13} Indeed not. If one first defines hypothetical A as better than B, no subsequent proof is necessary. But if one is claiming that one form of organization in the real world is or could be superior to another, some further evidence is called for. Krasny and Ferrier are in a cleft stick. Either the present American circumstances represent a “close enough” approximation to the “market environment” they have in mind, or they
do not. If they do, their claim fails monumentally on empirical grounds; if not, then the “environment” they find so self-evidently superior exists only in their own minds, a hypothesized—and none too clearly spelled out—dream world.

Nor are they alone. In her essay in this volume of Health Affairs, Patricia Danzon claims that “diverse consumer preferences are better satisfied [by markets that offer choices among insurance plans] than if all must accept a uniform public plan.” Further, “rationing through waiting is likely to lead to a less efficient use of the scarce facilities than is the case with rationing through price- and information-based systems. . . . [I]t is highly likely that limited beds and capital equipment [in Canada] are not being used to yield the maximum value to patients.” When one considers that no modern health care system is organized on market lines and that the closest approximation thereto (the U.S. system) is a uniquely unsatisfactory outlier, it is not difficult to see why advocates of the market prefer to rest their arguments on the (unspecified) characteristics of systems existing only in their own minds. The imagination becomes the source not only of the possible but of the inevitable.

Attempts to create a more efficient “market-based” system satisfactory to the American public have been tried for more than a decade and so far have clearly failed. Their advocates presumably feel that the failure is one of application, not of possibility, and that continued effort along these lines is justified. But their grounds for this conclusion seem only to be that they are able to imagine a hypothetical system they believe would be superior to any presently in existence. To paraphrase Danzon, “the relevant comparison for the national health insurance debate in the U.S. is between a public monopoly system” and a well-designed but practical private insurance system. Again, faith triumphs over experience, imagination over reality.

On the other side of the border, the system that Canadians overwhelmingly supported when it was introduced, and still do support, was based on an explicit rejection of the multiple private insurer model. The observation that the original universal, community-rated system run by voluntary nonprofit organizations was inevitably sliding into a private, market-based insurance system was a powerful stimulus to the introduction of a universal public program. There is no public support for reversing this decision. Canadians had a choice and still do. Many Americans say that they, too, would prefer a national health insurance system, but they do not have that choice, and Danzon does not think they should.

Predicting utilization response. Culyer’s “fundamental differences” appear to have undermined a serious effort by John Sheils, Gary Young, and Robert Rubin to inform the American debate. Their central conclusion is that the administrative savings resulting from moving to a single-
payer system will be swamped by a massive “utilization response.” We believe this prediction to be erroneous or at least unfounded. It is a straightforward consequence of the analysts’ underlying model of the utilization process, and its validity stands or falls with that set of hypotheses. No such massive utilization response occurred in Canada with the introduction of universal, first-dollar coverage.\footnote{There is strong evidence of a cumulative increase in utilization, relative to that in the United States, in response to the constraints on fee escalation that resulted from bargaining with provincial governments.\footnote{This differential, observed by Victor Fuchs and James Hahn in 1990, has emerged over roughly twenty years of tension between provincial governments trying to hold down fees and rapidly growing numbers of physicians trying to maintain their incomes. It is interpreted by Sheils and colleagues anachronistically, as evidence that a “utilization response” to “free care for all,” occurred at the beginning of the period. The well-established behavioral link between fee controls and utilization response, which is excluded from the theoretical framework employed by Sheils, Young, and Rubin invalidates their claim that one can “separate the potential cost savings due to health expenditure budgeting from the cost implications of Canada’s unique administrative model.”\footnote{The utilization response is a direct consequence of the administrative process that has been applied to fees. It did not show up at the introduction of the plans, where it is predicted by their model, because it arises not from the behavior of patients but from that of providers. That said, one should still be concerned about the potential for a “utilization response” to any national plan, arising from its effects on provider behavior. The United States of 1992 is very different from the Canada of 1967. A system that is awash with human and physical capacity and technical possibilities, and chafing under utilization constraints that, while ineffective in aggregate, are still onerous and offensive, might very well respond to the extension of coverage with a significant increase in recommended diagnostic and therapeutic interventions.\footnote{After all, one of the most common arguments for a universal system is to provide “needed” care for those left out at present. Thus, any program would have to have quite flexible and enforceable controls on who can be paid, for doing what, in what settings, and at what levels, to prevent runaway “creative billing.” While these controls would not be identical to those developed by the Canadian provinces (or the West European countries) over the past quarter-century, they would have to do the same job. But this is not news to public agencies in the United States that are responsible for reimbursement. The Physician Payment Review Commission, for example, is fully conversant with this foreign experience and has had to develop similar policies.}}}
The expansionary pressures that would come with a universal plan are simply scaled-up versions of the American present. The introduction of prospective payment for Part A of Medicare, but not for Part B, led to the rapid growth of ambulatory diagnostic services and costs and the proliferation of supporting “organizational innovations”—physician/hospital joint ventures—which further boosted use. During 1991, several legislative and regulatory changes were introduced to limit these opportunities for “gaming the system.”

But nobody in Washington should imagine that there is some final regulatory structure that, once found, can be left to run itself. That is a fundamental error. Payment for health care, in every system, is an ongoing contest between payers and providers. Predicting its outcome, in terms of “utilization response,” is akin to predicting the outcome of a horse race or a football game. Mathematical models, with analogies in physics, are notoriously unreliable for this purpose, because they are rooted in “games against nature” in which there is no organized human intelligence on the other side of the table or field.

The payment game is a tough one—too tough for most patients, which is why providers prefer to play against them rather than against institutional payers. American experience to date suggests that it is also too tough for private corporations; despite the predictions of a decade ago, their efforts to control health care costs by acting as prudent purchasers for their employees seem to have failed and are being abandoned. The problem is being passed back to employees.

A principal argument for universal public plans is, and always has been, that only concentrated public authority can balance the power of providers. A number of imaginative alternatives have been developed by advocates of the private sector, and one cannot rule out absolutely the possibility that one might someday work. But none does now, nor ever has. There are, by contrast, a number of variants on the “universal public” theme, which have managed to balance the interests of providers and represent, albeit imperfectly, the financial interests of citizens.21

By far the largest component of the “utilization response” assumed by Sheils, Young, and Rubin arises from the elimination of cost sharing in current American health insurance coverage. Their estimate is based on the results of the RAND Health Insurance Experiment. But that experiment was specifically designed to measure patients’ responses to a variety of user charges, holding constant, by assumption, the behavior of providers. It cannot therefore be used to draw conclusions about the behavior of entire populations of patients and providers. To do so is an elementary, but fundamental, fallacy of composition.

It is well known that all countries in the Organization for Economic Cooperation and Development (OECD), except the United States,
have in recent years reined in total health costs. In none are user charges of any sort a central or even a significant component of the control strategy. Only the United States, which already relies heavily on such charges, has failed to control costs. Moreover, as is perhaps less widely known in the United States, the principal advocates of such charges in other countries are providers, who explicitly argue the need for increased funding and see user charges as the most promising way to get it. This rather undercuts the view expressed by Sheils and colleagues that “much of [the] increase [in utilization] could be averted if patient cost sharing were part of a U.S. version of the Canadian model.” (Like the defenders of Singapore, they have their guns pointed the wrong way; their behavioral model says the Japanese must attack from the sea.) What they miss is that to date effective cost control has been based on direct regulation of fees and budgets. User fees are a way for providers to get around fee or budget controls, by tapping other sources of funds, and both they and the opponents of user fees are quite clear on this fact. If the payer refuses to grant a fee increase as large as requested, get it from the patient. And on the other side, the payer is much less likely to take the political heat required for cost control, if the increases can be passed on to, and blamed on, someone else—the patients.

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**Managing System Capacity And Costs**

Health care utilization is the outcome of a complex interplay among the perceptions, objectives, and constraints of providers and patients. Providers’ perceptions and recommendations of “appropriate” care are the primary factor influencing patients’ “demands.” These perceptions in turn are heavily dependent upon their own past practices and the present conventions and capacity in their professional communities. Prices, when present at all, have a minimal effect on overall use, although they may have more impact on who gets care, and for what. An important role, however, is played by changes in available capacity (personnel, equipment, institutions, and technology). If capacity is available, it is used. Thus, a key component of utilization management is capacity management, as indeed many Americans now recognize.\(^{22}\)

Within the constraints imposed by the levels of available capacity, the critical allocation decisions as to who gets what are made primarily by providers, in the form of their advice to patients and the referrals they make. Initial access to the system, at least in Canada, is *de facto* as well as *de jure* “free;” the “waiting lists” that play such a large part in American mythology about Canada simply do not exist in primary care. Indeed, there is increasing concern about an excess supply of primary care physicians in a number of locales. Referral for diagnostic work, specialist
care, or hospital services is under the control of physicians themselves, and they do the “rationing.” In effect, physicians in Canada run an internal “utilization review and management” system, within the externally set constraints on capacity. It is primarily through this process, rather than through queues and time prices, that capacity and use are matched and priorities established. And it is a generously resourced process; Canada’s is the world’s second most expensive health care system. If we are “underfunded,” then everyone else must be even more out of step—except the United States.

But, Danzon says, capacity management “imposes hidden costs of moral hazard control on patients . . . [via] excessive patient time costs that result from proliferation of multiple short visits in response to controls on physicians’ fees; diminished productivity and quality of life from delay or unavailability of surgical procedures; and loss of productivity due to underuse of some medical inputs.” These costs, she alleges, are large—exceeding “the measured overhead costs of private insurance.”

Vanishing distortions. Once again, we are dealing with a comparison between observable, recorded data on the one hand, and “estimates” based on a hypothetical model of behavior located in the mind of the analyst. These “costs” have no reality independent of that model. Danzon does refer to observations on changes in patterns of practice in Quebec in the early 1970s. But the conversion of these changes in patterns of practice into “costs” requires very specific, and highly questionable, assumptions as to the behavior, aspirations, and constraints of the “key actors” in the system. Furthermore, it presumes that whatever patterns predated universal coverage were in some sense “right,” or at least preferable to those that evolved subsequently. Preferable for whom, and on what standard?

The answer seems to be, preferable according to the ethical standard at the heart of the neoclassical economic model, that is, concordance with individuals’ willingness and ability to pay for goods and services whose value they fully understand. “Of course, copayments and utilization review entail rationing,” Danzon states. “But this is efficient . . . [and rationing by copayment entails no excess burden.” Thus, there is no need to calculate any hidden costs to Americans who are deterred by copayments from seeking care that would improve their health. One must be exquisitely sensitive to the “costs” imposed on those allegedly denied services which they “should” get, because they are willing (able) to pay for them. But no costs—or none that matter—are incurred by those who “choose” not to pay. Whether or not either group “needs” care never enters the model. Such an ethical position, once spelled out, may not be widely shared. It certainly cannot emerge as a conclusion from economic analysis. Rather, it is a prior philosophical position,
expressed through a certain style of analysis that does not and logically cannot provide any independent support for such value judgments.

But Danzon makes some significant empirical assumptions as well. The “hidden costs” allegedly generated by the public systems in Canada are inferred from a “before and after” comparison in Canada and then extended without comment to apply to a comparison between Canada and the United States of the 1990s. Does that mean that Canada before public insurance represented an “optimal” equilibrium, in the strong sense of the neoclassical-economic framework, and the United States does so now? That seems absurd, given what we know about the institutions and patterns in both places then and now. But if the baselines for comparison are not themselves competitive equilibrium states, then it is not possible to tell, a priori, whether the observed changes represent costs or benefits. 23 So Danzon moves the uprights. “The measure [of costs] here,” she states, “is excess time costs, over and above the efficient level required to receive medical care in a well-designed, competitive private insurance system” (emphasis added). Once again, we are comparing the analyst’s imaginary ideal with the grubby realities of Canada. But it gets worse. By assumption, the American present is closer to that ideal—indeed, for purposes of analysis, identical to it. Although “because of the tax subsidy and other distortions,” the current U.S. system “is unlikely to conform to this benchmark” (emphasis added), “the tax subsidy applies to medical and insurance inputs, not to patient time.” Therefore, “there is no reason to add an estimate of excess patient time costs to the estimate of U.S. overhead.”

Those “other distortions,” which include the influences of professional licensure, restrictions on entry and scope of practice, regulations and legal restraints in markets for drugs and institutional services, and the pervasive problem in imperfect consumer/patient information, obviously were not important enough to keep track of. And once they have disappeared, from the model at least, then one can use the rhetoric of efficiency to legitimate the competitive ideal.

By assumption, the U.S. system of health care finance and delivery embodies no significant distortions, relative to “a well-designed competitive private insurance system,” except for the tax subsidy. Well, that should be easy to fix with a few lines in the tax code. We have gone back twenty years, to Martin Feldstein’s diagnosis in the early 1970s. What then is everyone complaining about?

This breath-taking dismissal of all “other distortions” in the U.S. system, together with the imposition by assertion of an imaginary “ideal” system rooted in an ethical standard acceptable only to neoclassical economists and embodying behavioral assumptions that lack empirical support, then permits Danzon to select differentially only those hidden
patient costs that are alleged to arise in the single-payer system of care. There is no mention of the consumer costs incurred in the process of working through a mind-numbing array of “benefit” packages, nor of the patient costs associated with attempting to establish eligibility and collect those benefits. Information is perfect, or at least costless, in this imaginary world, and contracts are transparent and self-enforcing, so what costs could there be? 

Freedom from fear. Finally, and perhaps most important of all, are the costs to Americans, unmeasurable but not so hidden, of the uncertainty associated with the health and financial risks borne even by those who have coverage. The threats of financial ruin and/or denial of care are on the horizon of increasing numbers of Americans, or so they report. If one is concerned to take account of “hidden” patient costs, one might want to estimate these, although of course if one counts only costs borne by those willing and able to pay, then they do not count. In Canada, however, the Hall Commission specifically identified “freedom from fear” as a major benefit of the public plan.

Danzon, in fact, exactly reverses the Canadian and American situations when she refers to the higher “social costs of risk” borne by some hypothetical unemployed Canadian patient “unable to find a doctor if public deficits have stalled reimbursement through public programs.” It is in employment-based private systems that the unemployed lose coverage; in Canada, coverage follows from residency. And only in a system of multiple payers can providers withdraw their services from those covered by an insurer, such as Medicaid, not paying the “going rate” or paying too slowly. We have had our share of recessions: in the Canadian system, the scenario she envisages does not arise. Disputes over payment are resolved between governments and provider associations, and patients are not involved.

We freely admit that we do not know how large such “hassle and anxiety costs” are for Americans, although we, like everyone else, have heard some hair-raising personal accounts. Furthermore, we understand that most of the work of U.S. employee benefit managers consists of health insurance matters; these costs are also excluded both from the official statistics and from Danzon’s account. But the delivery of services is not Danzon’s primary concern. Much more important, she contends, is the loss of “efficiency” that occurs when “competitive” insurance markets are converted to single-payer systems. The large overhead costs, both in the insurance industry and imposed upon providers and consumer/patients, of a system of multiple private insurers have corresponding (hidden) benefits, which, when combined with the (hidden) costs for patients in a single-payer system, more than redress the balance.

Danzon alleges several specific types of benefits, but one general claim
reflects a profound misunderstanding: “[I]n the real world, where obtaining information and negotiating and enforcing contracts is costly, [over, head expenditures of insurers] can serve a useful function.” Indeed. Rational for-profit firms would not incur them otherwise. Such expenditures are essential for survival in a private marketplace. The key question is whether the private objectives thus served are consistent with the expressed objectives of the community as a whole. If that community has decided, for ethical reasons that are not consistent with Danzon’s model of the perfect market, that the whole community shall be covered and that the share of the costs borne by each individual shall not be proportional either to one’s risk status, or to one’s actual experience of use, then the underwriting and claims administration activities of private firms and the expenses that support them are indeed pure waste.

The private industry cannot “deliver the goods” (the conclusion that led the Hall Commission in Canada to recommend a public system) and so must devote its energies to convincing Americans that they should instead want whatever it can produce, at a large and growing cost. This raises a more fundamental question. If as even Danzon would concede the private industry cannot deliver comprehensive coverage and must, by the laws of the market, exclude those with the most significant health problems, then why is it worth “propping-up”? In particular, why should anyone presume that there is a public obligation to do so? The public sector already pays about 40 percent of the total U.S. health care bill, and an additional large amount through the tax subsidy, which Danzon suggests represents a significant market distortion. Could the private industry even survive without this public subsidy?

But do not American consumers “prefer” diversity? Damon states, “There is good reason to believe that the costs of the complexity and diversity of coverage in competitive insurance markets have more than offsetting benefits.” Americans may tell pollsters that they do not like the system and would prefer another, but they keep on buying. Here Danzon’s argument has become completely circular, Since the private system is the only game in town and consumers keep playing, this is alleged as evidence that any alternative would obviously be worse. But a similar expression of preferences through the political system, as for example by support for an alternative, has no evidentiary value at all in her theoretical reality.28

Danzon also offers specific benefits from the competitive insurance process, with particular emphasis on the role of private claims administration, which devises “ways to control moral hazard more cost-effectively.” To the extent that this refers only to the old story about user charges lowering overall use and costs by encouraging patients to be more selective in their use of care, it merely repeats the error made by
Sheils, Young, and Rubin and by every economist who ever drew a health care demand curve without thinking about it.

**Role Of Utilization Review And Management**

But Danzon’s comments on the role of utilization review (and management) are much more interesting. The emphasis on utilization review and management by third parties implies that individual patients, responding to price signals, cannot exercise effective control over health care costs, let alone weed out the least necessary or effective services. We strongly agree. Moreover, although we emphasized above that “utilization review and management” by physicians goes on in the Canadian system, as indeed it does in the American and everywhere else, we would not claim that the results could not be improved. There are currently a number of initiatives under way in Canada to improve this process.  

Where we and Danzon part company is with her blanket assertion that utilization review and management is more effectively carried on in a competitive, multipayer environment. This is not only empirically incorrect, in our view, but it is inconsistent with the theoretical framework underlying Danzon’s analysis. Utilization review and management focuses on the appropriateness and effectiveness of care—its relation to needs. It thus introduces a criterion for “what is to be done?” that bears no relation whatever to the “willingness to pay” standard implicit in her theoretical conceptualization of the process. Such a relation can of course be forced. But one must be prepared to assume that the individual consumers who are not well enough informed to distinguish beneficial care from the rest—hence the need for utilization review and management and for all of those “other distortions” of the competitive marketplace that vanished so smoothly above—are nevertheless able to make informed choices among the utilization review and management programs offered by competitive private insurers and compare them with their costs. Once this leap of faith is made, the rest is easy; whatever pattern of utilization review and management emerges from that market is “efficient” by definition.

Danzon claims that the incentives are more powerful in this competitive environment; that is an empirical question. But her “evidence” is only that relative to Canada and western Europe, the United States is overrun with utilization review and management activity. In this, it looks to us a lot like most other health care technologies. This is a process measure and says nothing about the effectiveness of all that activity. To date, no system can demonstrate outstanding success in this area, and utilization continues to climb. Furthermore, such activity is more overt in the United States, where it is marketed, than in other...
systems where it is not.  
Danzon also recognizes that utilization review is still in its infancy, but this does not seem to qualify her confident assertion that the competitive process will lead to an optimal “long-run equilibrium” pattern of utilization review and management. John Wennberg’s contrary assessment, that the incentives for and ability of providers to stay one step ahead of this process will continue to overwhelm the forces of the marketplace, seems to us better informed and more realistic.  
The key distinction, as Wennberg points out, is between utilization review and management as a way to improve the effectiveness with which a given quantity of resources is used, and utilization review and management as a mechanism to determine the overall volume of resources used. The former it may do; the latter, in all probability, it cannot. In any case, it has not. We suspect that the “long-run equilibrium” Danzon refers to would be a moving equilibrium, whose “optimality” is defined by the fact that it emerges from a competitive process involving private firms, allegedly responding to “the diversity of consumer preferences,” rather than by any external standard such as achieving cost-effective care.  
Single-payer systems, on the other hand, have demonstrated the ability to control overall costs; contrary to Danzon’s assertion, this does not represent “noninformation-based rationing.” Actual evaluations of care patterns suggest that the utilization process may be at least as well-informed in Canada as in the United States, and quite possibly better. The alleged “hidden cost from rationing[,] . . . that more serious medical complaints may go untreated,” appears to us to be the exact reverse of what actually goes on in Canada relative to the United States. It suggests quite an extraordinary pattern of behavior by physicians who allocate the available capacity. The phrase “price- and information-based” seems to imply that the two are the same or at least to encourage the reader to think so. There is, in fact, no connection between them.  
Thus her claim that “rationing through waiting is likely to lead to a less efficient use of the scarce [hospital] facilities than rationing through price- and information-based systems” presents a dichotomy that is doubly false: false because it presumes that access to care in Canada is determined through waiting in (first-in, first-out) queues rather than through physicians’ judgments, and false because it treats price and information as identical. It would be possible to improve the information base underlying present patterns of use in both countries, and a number of Canadians and Americans are working on this problem. Modifying the ways in which people are paid for their services may well form part of this process. But that has no logical connection with the pricing of services, or insurance coverage, to patients.
Perhaps the most jarring of many discrepancies between Danzon’s perceptions and ours is in her characterization of the role and benefits of the private underwriting and claims administration process. A somewhat different perspective is offered by Emily Friedman, who notes that the fiduciary responsibility of the private insurer (which the market also enforces) is to shareholders. Responsibility to policyholders is secondary— to the general public, nonexistent.\textsuperscript{33} She refers to underwriting practices, which “seem to many to be ruthless,” that have replaced “[r]easonably equitable” ones. We infer that these changes are not a reflection of the declining humanity of insurers, but a response to increasingly competitive market conditions—precisely Danzon’s solution to remaining “imperfections.” Coverage is not only difficult to obtain, but easy to lose—creating “insurance hostages” tied to jobs, Friedman continues. (This problem may be resolved if employers increasingly “go bare” and drop their coverage.) Moreover, she states, “the administrative cost issue is one of extreme vulnerability for private insurers.”

Friedman is not, of course, the last word on this subject—and certainly not the first—but she seems to put compactly the growing concerns of Americans, which are simply dismissed in Danzon’s account, where exclusions and limitations, experience rating, and administrative overhead, when “properly” perceived, are not problems but benefits. Compliance costs, misunderstandings and misinterpretations of horrendously complex policies, and the difficulties of making private insurers live up to their obligations are too unimportant even to discuss. After all, what do we have but anecdotes? Like Pangloss, Danzon assures us that this is the “best of all possible worlds,” or at least it can be made so by a “well-designed but practical competitive private insurance system.” For Danzon, the alternatives, which the citizens of other countries find not only tolerable but relatively satisfactory, have in fact large hidden costs of which they are apparently unaware.

In the end, we emphasize that the American debate is not about Canada. It is about American problems, and it will have American responses, if not solutions. External observers may take comfort from Winston Churchill’s optimism that one can always count on the Americans to do the right thing, after having exhausted all possible alternatives. But the history of American health policy suggests cycles, not convergence. And the predilection for misrepresentation and mudslinging, most recently displayed by George Bush in his comments on Canada in general and British Columbia in particular, has been encouraged by its recent success in the United States. Our reading of the situation (which is shared by many American observers) is that, on this issue, Churchill may just have got it wrong. But this difficult process of comparing alternatives will continue to be hampered by the creation of disinforma-
tion by “experts,” because there are too many players and not enough umpires. In Culyer’s words, “It is hard to distinguish [image from reality] since on the one hand, our images condition what we see (and what we look for) and hence in part determine our realities, while on the other hand, the realities we have experienced can limit the alternative images that we might invent about ‘how things might be’ in a reality yet to come.”34 This is particularly true when the issues are inherently very complex and charged with personal values, and when the different alternatives represent very different distributions of gains and losses.

So work out your salvation with diligence, and good luck.

NOTES

9. If one were to take at face value the claims of some critics of the Canadian system, Canada would have much to lose were the American system to end up looking like that of its neighbor to the north. In particular, as Damon points out, Canadians are accused of “free-riding” on American research and development and of being able to take advantage of the ready access to services and facilities in “short supply” in their own country. More substantially, and pointed out by a number of spokespersons for American business, the excess costs of the American system place Americans at a competitive disadvantage in international trade. Canada is one of their competitors.
10. See The President’s Comprehensive Health Reform Program (February 1992), chap. 6. This is but one of many gross distortions of the Canadian experience in a proposal that “nobody expects ... to pass Congress, not even Bush” (Michael Bromberg, director, Federation of American Health Systems, in Walker, “Poor State of Health”).


14. The model was laid out in M.V. Pauly et al., “A Plan for ‘Responsible National Health Insurance’,” Health Affairs (Spring 1991): 5–25. Such a private-sector alternative might include “compulsory, income-related premiums” (M.V. Pauly, presentation to Metropolitan Life Insurance Company, July 1991), which to the uninitiated sound very much like taxes. But they have the important distinction that they are collected by private insurers, not by any politically accountable body.

15. Royal Commission on Health Services, Report I (Hall Commission) (Ottawa: The Queen’s Printer for Canada, 1964), Chap. 18.

16. She is not alone. As Blendon and Donelan point out, the one survey that reports less than half of Americans polled as favoring a Canadian-style system was structured such that “the public [was] not given choices between a universal plan and the current system, or between alternative types of plans.” R.J. Blendon and K. Donelan. “Interpreting Public Opinion Surveys,” Health Affairs (Summer 1991): 166–169. The survey was commissioned by the Health Insurance Association of America.


19. J. Lomas et al., “Paying Physicians in Canada: Minding Our Ps and Qs,” Health Affairs (Spring 1989): 80-102; and Barer et al., “Fee Controls as Cost Control.”

20. The scope for this is large. B.J. Hillman et al., “Frequency and Costs of Diagnostic Imaging in Office Practice—A Comparison of Self-Refering and Radiologist-Refering Physicians,” The New England Journal of Medicine 323 (1990): 1604-1608, found that diagnostic imaging for patients with similar clinical presentations was more than four times as frequent, and fees about 40 percent higher, among patients of physicians who owned their own diagnostic equipment. There were no differences in direct charges to the two groups of patients.

21. Indeed, Pauly’s reference to “compulsory, income-related premiums” in an ideal private plan essentially concedes the point. Public authority is necessary to run an effective plan, but he would prefer to place it in private hands.


23. This intuitively plausible notion turns out to have a rigorous theoretical basis. On this, see R.G. Lipsey and K.J. Lancaster, “The General Theory of Second Best,” Review of Economic Studies 24 (1956-57): 11–32. At a very abstract level, it is demonstrable that if there is only one distortion preventing the attainment of a competitive market equilibrium, removal of that distortion will result in an improvement in efficiency, and a potential—but not guaranteed—improvement in overall welfare. But if there are two
or more distortions, then removal of one of them is as likely to lead farther away from theoretically defined “efficiency.” Thus, there is no basis whatever, even at a purely theoretical level, for any a priori claim of “efficiency” in real-life systems. The question is, as it has always been, an empirical one: How do different systems perform relative to standards that are themselves matters of public choice and cannot be derived a priori?  

There is in fact a fallback position. If one finds these assumptions a bit strong, the argument is that competition among private insurers will generate a level of information that is, if not perfect, at least the best that one can hope for. But this position has no more empirical content than the “perfect information” assumption, because by definition, whatever level of information emerges from “the market” is optimal. There is no external standard.

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27. These excess administrative costs are becoming subject to the same fate as estimates of the numbers of uninsured in the United States. Sheils and colleagues estimate them at $46 billion in 1991. Woolhandler and Himmelstein estimate $69 to $87 billion in 1987, which allowing for four more years is about double, and we fully expect soon to see figures on both sides of this range. But whatever the source, the number is big.

28. Of course, one might also point out that the neoclassical economic model “predicts” that decentralized decisions of a diversity of private consumers and providers, of risk bearing as of services, will lead to a more “efficient” outcome. But this is a technical usage of the word efficiency, which derives from theoretical welfare economics and has no normative significance. In the present context, it is a trap for the economically unwary, because it sounds like something good. It isn’t. To be more concrete, the organization of the illicit drug trade through private markets, such that no transactor can be made better off without making another worse off, is “efficient” in this limited sense. But this is not commonly advanced as an argument against the U.S. Drug Enforcement Administration.


30. One might note, however, that where utilization review and management systems are marketed for a profit, there are powerful incentives to make inflated claims for their effectiveness. In a politically and professionally managed system, the incentives are in the other direction, to downplay the existence as well as the impact of such activity. For better or for worse—and that too is an empirical question—implicit control is preferred to explicit everywhere but in the United States.


33. Friedman, “Insurers Under Fire.”

34. Culver, “The NHS and the Market.”