HEALTH CARE REFORM IN THE UNITED STATES: CAUSES, COMPARISONS, AND CONSEQUENCES

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Introduction

The need to reform the health care delivery and financing systems in the United States took center stage in the 1992 presidential election. Widespread dissatisfaction with the current health care system, and the desire to put a high priority on reform were instrumental in the election of Bill Clinton over the incumbent George Bush. Rising concern about the health care sector centers on three observations:

- The U.S. spends more on health care than any of the developed countries, both in absolute terms and relative to the rest of its economy.
- Despite the highest spending share, simple measures do not show that the U.S. is any "healthier" than other countries.
- In contrast to other developed countries, a large number of U.S. citizens are not covered by any health insurance.

In simple terms, it would be easy to conclude that the U.S. health care system is inefficient compared to systems in other countries, and that there are significant disparities in access to health care across income and age groups. Paradoxically, it is generally acknowledged that U.S. health care is the most technically advanced in the world, and that the benefits of "high tech" medicine are available to a large portion of the population.

Recent proposals to reform the U.S. health care system have aimed at (1) implementing systems that control costs, and (2) extending health care insurance to the currently uninsured and underinsured. There is lively debate about how to implement cost controls while maintaining the perceived quality of the U.S. medical sector. Seemingly straightforward solutions like direct price controls or overall outlay controls run counter to the U.S. tendency toward free market solutions. Analysts point out that price or other bureaucratic controls interfere with the allocation of resources and may lead to medical care rationing and long waiting lines.

Almost every developed country is facing some sort of crisis in medical care delivery and access. In Italy, for example, a recent OECD (1992) survey concludes that:

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> ...the functioning of the system has been unsatisfactory in many respects: the quantitative rationing of health care in response to continually expanding demand, often giving rise to long waiting lists for treatment...poor working conditions and organization have sapped the motivation of medical personnel; and the government has difficulty securing compliance with the financial constraints that it imposes. (p. 68.)

With most countries aiming at reforming aspects of their health sector, it is useful to consider the recent trends in the U.S. health care system and ask whether lessons learned from the U.S. experience can be useful to other countries. Likewise, the recent experiences in other countries can be instructive in shaping the eventual outcome in the U.S..

Health Care Spending Trends[2]

On a per-capita basis, the U.S. spends more on health care than any other developed country. Measured in dollars, spending in the U.S. averaged $2,566 per person in 1990, more than twice as much as the OECD average (Table 1).[3] Spending in Italy was close to the OECD average, while spending in Japan was slightly below the OECD average. Per-capita spending in the U.S. was also 30 percent above the next highest spender -- Canada -- ($1,770.). The U.S. also spent the most per-capita in 1980, but the gap between the U.S. and other countries widened during the 1980s. In percentage terms, the U.S. spent 213 percent of the OECD in 1990, compared to 176 percent in 1980.

One reason per-capita spending on health care in the U.S. is so high is that the U.S. also has the highest GDP per-capita, and medical care spending tends to be higher at higher incomes.[4] However, income differentials do not account for the entire difference between the U.S. and other countries. U.S. health spending reached 12.1 percent of GDP in 1990, the highest share of any developed country (Table 2). The ratio of health spending to GDP in the U.S. was 4.5 percentage points higher than the OECD average, and 4.4 percentage points above Italy's value. During the 1980s the U.S. share of health spending in GDP rose more than in any other country, up nearly 3 percentage points between 1980 and 1990. The health spending share in Italy rose 0.8 percentage points, the Japanese share rose only 0.1 percentage point and in Sweden (not shown), the ratio fell 0.8 percentage points.

Despite spending more, both in absolute terms and as a share of GDP, crude measures of health status do not suggest that the U.S. has a higher health "standard of living" than other OECD countries. For example, in 1990, the U.S. had the highest infant mortality rate of the Big

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[2]Data discussed in this section come from Scheiber, Poullier, and Greenwald (1992).

[3]The figures in the table have been converted to U.S. dollars using recent OECD estimates of purchasing power parities. This keeps differences in spending caused by changes in the exchange rate to a minimum. See Scheiber, Poullier, and Greenwald, Table 36.

[4]Again, using purchasing power parity exchange rates to convert all GDPs to dollars.

7 developed countries. Even with the rapid U.S. spending growth of the 1980s, other countries improved their infant mortality rates more than the U.S. between 1980 and 1990. In addition, the U.S. had the lowest life expectancy at birth for both men and women in 1990, compared with the other Big 7 countries.[5]

A slightly different picture emerges when looking at life expectancies at age 80, however. The U.S. ranks first for female life expectancy (1989 data) and ties for first with Iceland for male life expectancy at age 80. The difference in country rankings for life expectancies overall versus expectancies at advanced age may reflect differences in health care access across age groups within the U.S. Access differences likely reflect the institutional arrangements for financing and delivering health care.

How U.S. Health Care Financing and Delivery Is Organized[6]

The U.S. health care delivery and financing system is unique. In contrast to other developed countries, the U.S. relies heavily on the private sector to deliver and finance individual access to health care. Private health spending accounted for 58 percent of total health spending in 1990, which, compared to other OECD countries, was the highest private spending share of all countries except for Turkey. In Italy the share was 24 percent, nearly equal to the OECD average. In general, about a third of U.S. health spending is covered by payments from private insurers and slightly less than 20 percent by direct consumer purchases.

Private medical care insurance provides a way for consumers to trade a steady stream of costs (the insurance fees) for protection against large medical care bills that arise unexpectedly. Consumers and employers pay set fees (premiums) to insurance companies. In turn, insurance companies usually pay a large portion of the medical care costs consumers incur. There are two main types of private insurance. Fee-for-service plans allow enrollees to visit any doctor or hospital of their choice. The insurance company pays for some portion of the medical fees, usually a fixed percent of the cost after a threshold level (a deductible) is paid by the consumer. Consumer liability is often limited to some maximum amount of spending. Nearly 60 percent of privately-insured, private-sector employees are covered by fee-for-service plans.

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[5]These simple measures may give a misleadingly dismal picture of the effectiveness of U.S. health care. For example, there is very wide variation in infant mortality and life expectancy across income and racial classes in the U.S. Further, the relative diversity of the U.S. population compared with other countries may contribute to variation as well. Finally, the simple measures do not address the quality of care that patients receive when they are ill. No direct quality-of-care data are available. However, it is possible to infer from some available data that the U.S. has high care quality compared to other countries. For example, in 1989, the U.S. had the highest hospital staffing ratio (number of staff per occupied bed) of the Big 7, at slightly more than 3. That was well above the Italian figure of about 1. Further, across all types of disease categories, the average lengths of hospital stays was typically much lower in the U.S. (6.5 days in 1988) than in other countries (Italy's value was 11.2 days). See Scheiber, Poullier, and Greenwald, Tables 4-18.

[6]U.S. data related in this section come primarily from the Economic Report of the President, 1994. International data are from Scheiber, Poullier, and Greenwald (1992).

The second major type of health insurance is the health maintenance organization (HMO). These are organizations of health care providers, that, for a fixed per-capita fee, provide medical care virtually free of charge to their enrollees. While fee-for-service plans offer consumers the ability to choose their own doctor or hospital, HMOs generally restrict enrollees to use doctors and hospitals that are part of the HMO. However, HMOs typically charge lower premiums than fee-for-service plans.

For the most part, private insurance is obtained through employers. This system largely arose during World War II, when wages and prices were fixed. Employers attempted to use non-wage benefits as a way of raising labor compensation to attract and keep qualified employees without raising money wages. This system became institutionalized over time, especially through union bargaining. Currently, employers and employees each contribute to the insurance premium payments, with employers contributing slightly more than 80 percent of premium costs on average.

An important aspect of private health insurance is that employers are not required to offer health insurance as part of the labor compensation package, nor are there requirements about what medical services must be covered in any health insurance package.[7] Even if health insurance is offered by an employer, there is no requirement that an employee must enroll in any of the available plans. A recent estimate suggests that there are over 1,000 private health insurance companies in the U.S., each with its own rules about what procedures are reimbursable and how much the insurer will be paid for each procedure.

In general, private insurance companies are regulated by state insurance commissions. Yet in many cases, insurance companies are free to restrict eligibility and what is covered. For example, many insurance companies do not cover costs associated with medical conditions that existed prior to the applicant being accepted into the insurance coverage. These pre-existing condition clauses can include congenital conditions. The clauses have the effect of keeping some people in jobs that they might otherwise have left if their insurance were portable, that is, if they had independently contracted for health insurance.

A further major result of tying health insurance to employment is that access to health insurance is then tied to the business cycle. As unemployment rises during a recession, effective access to health insurance declines. Public assistance programs help to mitigate some of the effect, but there is no specific program aimed at health insurance for the newly unemployed as a group.

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[7]There is a tax incentive to offer health insurance, or to substitute increases in health insurance contributions for wage income, that helps to keep health insurance tied to employment. The federal government does not count employer contributions for health insurance as consumer income. Thus, an employer would only have to spend a dollar to increase health contributions by a dollar. If the employer were to give the employee cash to raise health contributions by a dollar, the employer would have to pay the employee more than a dollar to compensate for the income tax (about 28 percent).

Public Programs

Many different public programs provide either health care financing or health care services directly. The two most important programs are Medicare and Medicaid, which were both born during the "Great Society" burst of social programs that occurred in the mid-1960s.[8] Neither program provides health care directly. Instead, program participants largely get health care from private providers and these providers are reimbursed by the programs.

Medicare is aimed at the elderly, who typically require more medical care and therefore face higher medical costs than the rest of the population. There are two parts to Medicare. Part A of the program is like a government-run hospital insurance program, providing coverage for hospital expenses and a limited number of other health expenses. This part of Medicare is funded by a 2.9 percent payroll tax. Part B of Medicare provides supplemental medical insurance to cover surgical procedures done outside of a hospital and other doctor visits and costs. People who enroll in Part B pay premiums that cover about a quarter of the costs of the program. Medicare eligibility is largely based on age, with eligibility beginning at age 65.

Medicare outlays grew rapidly during the 1980s, with annual growth averaging about 10 percent. In comparison, the beneficiary population rose only 1-to-2 percent a year during the last decade. Medicare sets payment rates for particular procedures, but there are no limits on the overall size of the Medicare program.

Medicaid is aimed at the poor. Only those with low income (and low wealth) are eligible. It, like Medicare, reimburses hospitals and doctors who treat enrollees. Each state in the U.S. administers its own version of Medicaid, and reimbursement rates vary by state. Slightly more than half of the funding for the Medicaid program comes from the Federal government in the form of grants to the states, and the rest of the program is funded by various means within each state. During the 1980s, state and local health-care spending rose about 10 percent annually, while state and local revenue rose slightly more than 7 percent. Because Medicaid is also an entitlement program, overall costs are determined by the health status of the enrollees, not a budgetary ceiling.

Many Uninsured[9]

Government health programs cover only certain demographic and income groups. At the same time, private insurance is a voluntary arrangement between employers and insurance companies. As a result, there are a considerable number of uninsured people in the U.S.. Estimates suggest that, in 1992, more than 15 percent of the population were not covered by any kind of health

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[8]There are a variety of smaller programs that serve limited populations. A notable large exception is provision of medical care to members of the armed forces through the Defense Department, and Veteran's hospitals, through the Department of Veteran's Affairs.

[9]Data for this section come primarily from the Economic Report of the President, 1994.

insurance throughout the year. Estimates for 1990 suggest that about 85 percent of the uninsured were either working for employers who did not provide health insurance as a benefit or were dependents of those workers. In many cases these employers were small businesses who cannot afford insurance for their employees.

At least two factors work against small business acquiring private insurance. First, administrative costs per enrollee are higher for a small business than for a large business. This tends to raise the average premium small business must pay. For example, the administrative cost per dollar of claims paid for small business (less than 100 employees) varies between 20 cents and 40 cents, while the cost per dollar of claims paid for large firms (more than 2500 employees) varies between 5 cents and 8 cents.

Second, private insurance is "experience rated", that is, those with higher expected medical costs pay more for insurance. Because they do not have a large pool of employees across which risks are shared, which brings down the average expected insurance premium, small business are charged higher insurance premiums than larger firms.

Of course, being uninsured does not typically deprive the uninsured of all medical services. Estimates suggest that the uninsured spend about half as much on medical care as the U.S. average. It appears that the uninsured do not make use of routine medical care, or preventive treatments. Treatments are administered in emergency situations, often in hospital emergency rooms, which are costly relative to other treatments. Because the uninsured usually cannot pay the entire cost of treatment, the treatment costs are shifted to other patients. This is typically done by raising the prices of procedures to those not facing fixed reimbursement rates -- private insurers. Estimates suggest that bad debts and charity care accounted for nearly 11 percent of all costs incurred by hospitals in 1991 (CBO 1993, p. 58)

What Generates High Spending?

Some argue that the U.S. health financing and delivery system itself fosters rapid price increases. Compared with other countries, overall health care prices have risen 2.2 percentage points faster than the overall rate of inflation (Table 3). Many analysts point to the prevalence of third-party payers as a reason for rapid price growth. These analysts argue that because consumers bear little of the direct cost of health care, they are less sensitive to price increases and have little incentive to economize on health care purchases. Fee-for-service private insurance plans are particularly singled out, because under those plans neither the consumer nor the care-provider has any economic incentive to search systematically for lower cost alternatives to diagnostic tests or other medical procedures.
HMOs, where the financial health of the HMO depends on the efficiency of managing enrollee care costs, are pointed to as an organizational structure that is not as susceptible to rapid cost increases.

The experience of other countries also points to fee-for-service insurance plans as a major contributor to higher health care inflation in the U.S. In most other countries, consumers are

even more insulated from medical care prices than in the U.S. However, these systems usually have cost controls on third-party outlays. In Canada (where the difference between medical price inflation and general inflation was nearly as large as in the U.S.) the provinces set budgets for hospitals directly and physician fees are the result of labor negotiations within each province. In Italy, the appropriations of the National Health Fund are decided on annually during the development of the budget. General Treasury revenue makes up the difference, if the outcome exceeds the budgeted appropriation.

It is a mistake to focus too closely on excess medical care inflation as an indicator of the failure of the U.S. health care system. Medical care inflation measures only one aspect of medical care. Analysts argue that while other countries have lower health price inflation, they also tend to have longer surgical waiting periods and more bureaucratic requirements to access advanced diagnostics. Thus, the relatively freer medical market in the U.S. allows prices to rise, while cost controls in other countries force the quantity of medical care to adjust. Because prices are easier to measure than are other aspects of medical care, the U.S. appears, at first glance, to be not as efficient as other countries.

Italian dissatisfaction with their medical care system illustrates these non-price problems. A recent OECD overview of the Italian economy (1992) reports that long waiting lists have developed for elective surgery and consulting with specialists. Twenty-six percent of persons requiring hospitalization had to wait more than 15 days to be admitted. Recently Italian citizens have been authorized to seek treatment abroad if they are kept waiting more than a specified time. Further, forty-six percent of doctors do not believe there is enough medical equipment available. Bureaucratic control of the health care system has apparently led to widespread corruption in setting prices and contracts to build new hospitals (Drozdiak, p A-3).

In the U.S., recent attempts to control costs have come mainly through setting up strict allowable reimbursement rates for particular procedures for those enrolled in the two main government programs. These controls have been successful, but some of their effect has been blunted in overall spending because these rates only apply to the government-financed medical purchases, which is a smaller part of medical purchases than in nearly any other country. Thus, the existence of a large private insurance sector, which does not face outlay constraints, allows doctors and hospitals to recover losses from low government reimbursement rates from patients with private insurance. This cost shifting raises private costs overall and helps to propel overall medical prices.

In addition, analysts argue that physicians have been successful at switching from procedures with low reimbursement rates to procedures with higher rates, or at simply increasing the number of diagnostic tests and procedures done on each patient. Such shifting is not difficult to do, given the inherent uncertainty surrounding many medical diagnoses and the laudable, but perhaps not cost-effective, attempts by medical professionals to make more positive diagnoses.

Many analysts point to the interaction of the health care financing system and the tendency for "high technology" medicine as a driving force in rising medical care prices. New technology

increases the number of tests that are available and the scope of treatments available. The use of "high tech" medicine is partly responsible for the relatively high quality of medical care in the U.S. Private doctors and hospitals acquire the equipment to attract consumers to their facilities. Thus, competition forces relatively rapid diffusion of new machines and drugs. A recent study found that the U.S. has about 4 times the number of open-heart surgical units and magnetic resonance imaging machines per person than Canada and Germany (CBO 1992, p. 23.).

However, new treatments and technologies are typically expensive. New, relatively expensive machines must be depreciated quickly in order to recover the costs of investing in them, before they become outmoded. Consumers typically pay little of the cost of the test or the treatment, and are largely insulated from the cost of the tests. Insurance companies can raise their premiums on large groups in response to medical care cost increases arising from relatively infrequent, but very expensive treatments and diagnostics. Thus, rapid improvements in medical technology can drive up prices, even if the improvements are targeted to a narrow group of patients.

Economic Implications of High Spending: Is It Sustainable?

Rapidly rising medical costs and dissatisfaction with the current system in the U.S. suggest that the current system will not continue very far into the future. Even with the smallest direct government share of medical spending of all developed countries, government budgets in the U.S. are under severe pressure from rising medical costs. For example Medicare costs will likely be about 11 percent of the federal budget in 1994 and are projected to rise to 18 percent of the federal budget in 2004. Federal outlays for Medicaid are projected to rise from nearly 6 percent of the federal budget to more than 10 percent in 2004. Together, these two programs, which will likely account for 17 percent of the federal budget in 1994, will account for nearly 30 percent in 2004 (CBO 1994, p. 29).

At the federal level, rising medical care costs could be financed by running a deficit. However, the federal budget has been in deficit continuously in the 1980s, with the deficit already in the neighborhood of 2-to-3 percent of GDP. The existence of a relatively large federal debt -- the accumulation of past deficits -- constrains the ability of policymakers to rely on deficit financing any further. In the longer run, if medical care costs at the federal level continue to climb, policymakers will be forced to reduce other services or raise taxes.

States also face budget pressure from rising medical care costs, since they contribute about 45 percent of the budget of the Medicaid program. Unlike the federal government, where deficits can be used to finance continued outlay growth, many states are required by law to run a balanced budget. As a result, rising medical care costs put immediate pressure on states either to raise taxes or reduce other services.

The private sector also faces pressure from rising medical care costs. Because the supply of labor is not very elastic with respect to labor compensation, when premiums for private health care insurance rise, take-home wages are reduced. Thus, rising health care costs put upward

pressure on private insurance premiums, which are part of the total labor compensation package. If the overall compensation package is largely unchanged, or rises only with improvements in labor productivity, take-home wages and other benefits would be reduced. This occurred during the 1980s to some extent, when, adjusting for inflation, wages in the U.S. grew a very sluggish 0.8 percent a year. In general, slow growth in discretionary income produces slow growth for nonmedical goods. In sum, rising health care costs are likely associated with lower demand for goods purchased with discretionary income.

The prospects of continued stagnation in discretionary wage income may also have implications for the number of uninsured. Even if employers continue to offer insurance, employees may choose not to enroll in order to enjoy higher take-home wages. Yet this would tend to raise the number of uninsured, which, through cost-shifting, would put even more upward pressure on government programs and further raise private insurance premiums.

Reform Ideas: The Clinton Plan[10]

Most reform plans address two major issues: (1) providing insurance to the currently uninsured and, (2) controlling costs. The most comprehensive reform package was proposed by the Clinton administration, although there have been several previous legislative proposals introduced over the last few years, including national health insurance. The Clinton proposal has four basic parts.

First, the plan extends insurance coverage to the uninsured and underinsured, but largely maintains the U.S. system of private health insurance. All U.S. citizens will belong to one of several regional health alliances, which regulate and standardize private health insurance programs. Each health alliance would provide consumer information about private insurance plans, collect premiums and disburse funds to private insurers.

A key difference between private insurance under the Clinton plan and private insurance under the current system is a switch from experience rating to community rating. That is, health insurance premiums would not differ among individuals with different medical conditions. Further, insurers would not be able to deny insurance on the basis of pre-existing conditions. This feature of the plan moves the U.S. toward a system of universal coverage that is similar to other developed countries.

The second part of the Clinton plan maintains the U.S. connection between employers and health insurance. All employers are required to offer health insurance to their workers. Employers are required to contribute roughly 80 percent of the average cost of insuring an employee. Employees would have to pay the difference between the overall costs of their insurance and the standard contribution that the employer would make. Large employers may either elect to join a regional health alliance, or, if they feel they can administer their own plans

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[10]This section draws heavily on the Economic Report of the President, 1994 and Health Security: The President's Report to the American People, 1994.

more efficiently, become their own alliance. Maximum amounts on what small firms (and low-income individuals) have to pay for health insurance are set, and government subsidies cover the rest of the cost. Small business would be able to offer insurance at large-business rates because the insurance risk would be shared across a large group of health alliance members and administrative costs would be lower.

Employer mandates are the most controversial and, to some sectors, potentially the most costly element of the plan. Firms that currently offer minimal or no health care coverage will find their costs rising substantially. In general, these firms are concentrated in the service sector, with a high concentration in retail trade, construction, restaurants, and similar businesses. At the same time, costs for some firms will fall. Declines in costs would occur for firms that would no longer have to pay premiums that cover the cost of the uninsured and underinsured. However, government subsidies for small business and low-income individuals could be quite large.

Third, the plan aims to reduce medical care cost increases overall. Proponents suggest that costs will be lowered because the plan reorganizes the way health insurance is purchased and how health costs are monitored. They estimate that the savings in administrative costs from moving to the Clinton plan would be between 3-and-4 percent of total claims paid (about 1-2 percent of total health expenditures). In the event that these gains in managerial efficiency do not adequately constrain costs, control mechanisms are imposed. For example, if health insurance premiums rise too quickly in one year, so that premium guidelines are violated, the guideline is lowered in the next two years and health insurance premium increases are limited by law to the lower rate of increase. Thus the plan provides a back-up system of price controls if efficiency gains from reorganizing the way private health insurance is purchased and used do not control costs sufficiently.

This aspect of the plan has raised considerable protest from those who believe the inefficiencies generated from price controls will overwhelm the benefits from smaller increases in spending. Free-market economists believe that the administrative control of premiums will lead to surgical waiting lines, lower quality care, and increasing opportunities for corruption. They also point out that financial gain has largely spurred the relatively rapid diffusion of medical technology, and that blunting the financial incentive will lead to a less innovative U.S. medical sector.

Finally, the plan includes some tax increases. Higher taxes are levied on tobacco products, and there are small payroll taxes levied on firms that choose not to join a regional health alliance.

Economic Effects of Reform on the U.S. and Other Countries

Health care reform will have two types of economic effects. First, health care reform will change the health care sector itself. The primary issue here is whether the quality of health services provided will remain constant, decline, or improve with health care reform. So far there has been little agreement about effects in this area. A major obstacle to analysis is that most

economic models are useful only for incremental changes, while the Clinton proposal will restructure the financial incentives inside the health sector itself. Another obstacle is lack of agreement among analysts on measures of quality of health care services provided. Proponents of health care reform believe that "quality" will be maintained or even improved slightly. They point out that the emphasis on preventive medicine in the Clinton plan could improve health status overall. Outlays on preventible illnesses or conditions would likely decline. Opponents point to situations like the recent Italian experience to emphasize the danger of administrative controls.

More work has been done on the second type of economic effects, namely, how reform will affect the rest of the economy. These effects are primarily felt through their impact on overall inflation, costs facing the nonmedical sectors, and government budget balances.

A recent evaluation of the Clinton proposal by the U.S. Congressional Budget Office (CBO, February 1994) suggests that if the plan is successful in reducing the rate of growth of health care spending, by 2003 the plan will have little impact on the total number of jobs in the economy or on the federal government budget deficit. In the shorter run, the CBO notes that by 1996, health costs facing business would be below what would have occurred in the absence of reform. Thus, overall, business costs would be lower. Although the CBO suggests that there will be large increases in costs facing some industries, it does not offer estimates about what the implications of these inter-industry effects will be on employment, prices, and income. Finally, CBO notes that the Federal deficit will be higher under the Clinton proposal through 2003, mostly due to subsidies that the federal government pays to small business and low-income individuals. By 2003, the federal debt is estimated to be $74 billion higher under health care reform, an increase of less than half of one percent.

A more comprehensive review of the Clinton plan has recently been conducted by Monaco and Phelps (1994). Like the CBO study, it is silent on the impacts of reform on the health care sector itself. However, it projects the effects of the plan over a longer time period than the CBO study and is conducted using a model that has industry detail about employment, output, and prices.[11] The study shows effects similar to the CBO results through the first few years of the plan (which, like the CBO study, includes a four-year phase-in period). These include small declines in real GDP in the short term, and modest increases in the federal deficit.

However, the simulation shows that between 2003 and 2010 the plan will significantly lower the inflation rate, raise real GDP, and reduce government deficits. Much of this economic effect of the plan comes about through the effects of lower rates of medical care price growth on the overall inflation rate. Annual inflation between 2003 and 2010 is almost a full percentage point lower under the Clinton plan. As a result, real wages are higher. Further, as medical inflation slows, so does the rate of growth of medical insurance premiums. This raises the share of

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[11]The model used is the LIFT model, developed at the INFORUM project at the University of Maryland. See McCarthy (1991) for a description of the model.

discretionary wage income in overall labor compensation. Increased discretionary income raises demand for nonmedical goods, raising employment.

Lower medical care inflation tends to reduce pressure on both the federal and state and local government budgets. If states and localities chose to reduce income tax rates in response to lower costs, rates would be about 0.2-to-0.3 percentage points lower with lower health care spending. The federal debt would be about 5 percent lower in 2010 with health care reform than without. Although the results of this study were generated by looking at the Clinton plan, similar effects would be likely for any plan that could reliably reduce the rate of growth of overall health spending, especially if much of the reduction was the result of lower medical price inflation.

Conclusion

Health care reform is at the top of the political agenda in the U.S. and in several other countries, including Italy. The U.S. and the Italian systems appear to be converging toward a system that guarantees insurance coverage and medical care to all, and which attempts to control health care costs by combining the price system with some form of administrative control. However the U.S. and Italy are converging from different ends of the health care system spectrum.

The U.S. seeks to improve the scope of available health care coverage and introduce administrative mechanisms to control costs. There is a strong bias toward trying to accomplish these ends by making use of the price system, rather than relying on governmental controls. The Clinton proposal makes coverage universal, and cost containment is accomplished mostly through increasing administrative efficiency and in promoting insurance schemes more like HMOs than fee-for-service plans. The private sector is still the predominant health care provider.

The Italian system appears to be grappling with the effects of their particular implementation of universal coverage. The right to equal access was established in 1978, but the system of national, regional, and local institutions begun at the same time has not been able to control costs while providing satisfactory service. High-income earners have been increasingly funding their own medical care, either through direct spending, or to a smaller extent, through insurance. Recent reforms have been aimed at providing more fiscal responsibility at the regional level. Consumer copayment rates have been raised to give incentives for a more efficient use of available resources. There is some call to encourage more competition among health care providers as a way of improving resource use.

In general, it appears that the U.S. is moving slightly in the direction of more overt public involvement in the financing of health care, while Italy is considering moves that would turn more of the provision of services to the private sector. Whether these reform agendas will converge to produce a successful hybrid of institutions and mechanisms remains to be seen.

TABLE 1

Per-capita Health Spending in U.S. Dollars using OECD purchasing power parity exchange rates		
	1980	1990
Canada	773	1770
France	736	1532
Germany	856	1486
Italy	600	1236
Japan	540	1171
United Kingdom	474	972
United States	1064	2566
OECD Average	604	1204
Source: Scheiber, Poullier, and Greenwald, p. 5.		

TABLE 2

Health Spending as a percent of GDP		
	1980	1990
Canada	7.4	9.3
France	7.6	8.8
Germany	8.4	8.1
Italy	6.9	7.7
Japan	6.4	6.5
United Kingdom	5.8	6.2
United States	9.2	12.1
OECD Average	7.0	7.6
Source: Scheiber, Poullier, and Greenwald, p. 5.		

TABLE 3

Health Care Inflation less GDP Inflation, 1980-90, percent per year	
	1980-90
Canada	1.9
France	-1.1
Germany	0.4
Italy	0.2
Japan	0.7
United Kingdom	1.2
United States	2.2
Source: Scheiber, Poullier, and Greenwald, Tables 3 and 34.	

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