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Little to learn from the Americans

Although the British are forever looking across the Atlantic for solutions to their problems, Evelyn Waugh thought that they had little to learn from the Americans. Judging from last week's conference on American health care and its lessons for Britain, which was organised by the Institute of Economic Affairs, Waugh may have been right—at least for health care.

A defect in the conference was that the speakers and the audience were talking about different things. The American speakers talked mostly in financial terms, urging competition and incentives, whereas the British audience wanted a broader discussion relating to a health service where cost containment is not the main weakness and where incentives are needed to encourage all NHS units to perform to the standard of the best.

In the United States in the early 1980s health care funders—insurance companies, employers, and the government (which provides 40% of health care funding through Medicare and Medicaid)—became alarmed that costs were doubling every four years. In order to control costs and increase competition the funders introduced measures such as prepaid care plans, contracts with hospitals, and the use of diagnostic related groups. As a result hospitals' revenues fell, but some of the costs were simply displaced. Payments to doctors and for outpatient procedures rose because they were not controlled, and "clinical laboratory testing became a new profit centre for physicians," remarked Dr Robert Helms, adviser to the Reagan administration on federally funded health care. Although competition has reduced costs (by about 15%), it can do so only once, and costs are now rising on the same trajectory as before—about 6% a year. Professor Mark Pauly of the University of Pennsylvania, who thought that the United States had almost achieved a competitive system in health care for those who were neither poor nor elderly, was not bothered by this rate—by definition it was the right rate because it was set by the market. Nevertheless,

much of this growth is accounted for not by an increase in the volume of services but by higher payments for providers and higher intensities of treatment, and he did concede that it provided no solution to the problem of equity. The poor remain a problem in the free market.

Professor Pauly's prescription was to encourage health providers to offer different intensities of care—from the Ritz health plan to the Spartan health maintenance organisation. "We need," he said, "to develop a language for talking about the limitation of useful care." Professor Clark Havighurst, a specialist in the use of antitrust law to break up doctors' restrictive practices, was less reticent about what "the limitation of useful care" might mean: questioned about what would happen to the patients of health maintenance organisations that ran out of money and had to ration care (and most are now losing money and raising their subscriptions), he answered that the model of consumer choice suggested that the organisation would have to specify that after a certain age you could not expect certain treatments. Sadly there was no discussion on the advantages and disadvantages of fudging these decisions—as the NHS does¹⁻³—or being explicit about them.

The lack of lessons for Britain from the American experience was perhaps built into the occasion. As Rudolf Klein graphically put it, you cannot expect a patient with anorexia to learn much from one with obesity. Britain eschewed a free market for health in 1948: nothing said at last week's conference suggested that it was wrong to do so.

JANE SMITH

Assistant editor, *BMJ*

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