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WORKSHOP IN HEALTH ADMINISTRATION STUDIES

WINTER, 1989

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"Comparative Health Insurance: Cross-national Comparisons with Lessons for the United States"

WORKSHOP PAPER

for

Thursday, February 9, 1989

Rosenwald 405

3:30 to 5:00 p.m.

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DEPARTMENT OF HEALTH SERVICES ADMINISTRATION

NATIONAL HEALTH INSURANCE IN PRACTICE

William A. Glaser

A condensed version was published as "What Can We Expect from National Health Insurance?" Columbia (The Magazine of Columbia University), Volume 4, Number 3 (Winter 1978), pp. 31-33.

NATIONAL HEALTH INSURANCE IN PRACTICE

Americans say they are about to enact national health insurance, but they are not clear about what it really is. Uncertainty worries many policymakers, lest they commit the country to great expenses or to excessive government control. Therefore, Washington experiences constant swings in influence between leaders who say that action is long overdue and advocates of further delay.

Because of the uncertainty about what national health insurance is, many interest groups push their own schemes and claim these will be sufficient. Most are merely expansion or governmental subsidization of the present situation, serving the self-interest of the sponsoring groups.

If the United States is the world's last developed country to enact national health insurance, the subject should not be so mysterious and confusing. America need only look at the many other countries that have long had it, in order to learn how to design it and in order to learn whether any of Washington's anxieties are vindicated

WHAT DIFFERENCE WOULD IT MAKE TO THE PATIENT?

National health insurance is simply a way of paying doctors, hospitals, and other suppliers of health services on a large scale. Both inpatient and ambulatory care are covered; in almost every country, all or nearly all citizens enjoy benefits. Usually it makes official and expands the forms of delivering medical care that had existed earlier.

The typical patient, therefore, gets the same types of benefits that he enjoyed before, viz., office care by doctors, hospitalization, drugs, and

some prostheses. But they are paid for differently, since national health insurance is supposed to be an improvement in system of payment. Often in the United States today, the patient never knows in advance the size of the bill, how much will be paid by the insurance carrier, and how much he himself will be expected to pay. Perhaps no-one knows, except for the computer programmed by the insurance company with the benefit coverage and formulae for his particular policy. Only when the computer processes his bills does he get the good (or bad) news. These variations among many policies and this confusion is not possible under national health insurance. Coverage of benefits is standard for large numbers of persons and is commonly known; if the patient is expected to pay any costs, everyone knows this in advance.

National health insurance tends to level payments: the rich patient is rarely more profitable to doctors and hospitals than the poor patient; gradually the rates in rural areas approach those in the biggest cities. As a result, access to care becomes more equal. Since the poor patient is just as profitable as the rich patient and since a doctor or hospital cannot earn high incomes by competing for a few rich patients at high prices, they are willing to serve everyone. If competition in big cities is too stiff, then doctors and other providers are willing to work in rural areas and in towns. In many countries, national health insurance laws promise to provide the patient the full list of benefits, and therefore governments, medical associations, or carriers try to place doctors and facilities in underserved areas.

WHAT DIFFERENCE WOULD IT MAKE TO THE DOCTOR?

American doctors warn against adoption of a national health service that would impose government controls over them. But "national health insurance" is not a "national health service." The latter is a method

of employing nearly all doctors--often, but not always, on salaries. Examples are in Great Britain and Sweden.

But national health insurance is merely a method of payment. As in the enactment of any public policy, a political deal is struck between the medical profession and government. In return for the doctors' cooperation, health delivery is not altered. Doctors remain in office practice, if they wish. Hospitals stay in voluntary hands, if that is the custom. Patients and doctors are guaranteed free choice. Government is limited to setting rules and collecting money.

Since national health insurance is a public program that requires predictable budgetting, each doctor must follow certain rules. In particular, his charges must follow a fee schedule. However, the rules and fee schedules are not imposed unilaterally upon the doctors by government. Rather, they result from collective bargaining between the medical association and the health insurance carriers.

In each country with national health insurance, the existing medical association continues to perform the scientific services of any professional association. In addition, it becomes the profession's representative in dealing with the health insurance funds and with the government. It becomes a system of representative government, so that doctors from different regions and from different specialties develop collective positions about terms of service in health insurance and about money. Medical associations pick a new type of leadership, skilled in economic planning and in negotiation.

Doctors profit financially, instead of losing. During the first years of national health insurance, the health insurance carriers and the government try to "buy" the profession's cooperation by levelling all fees up to

those collected by the higher-priced physicians. In contrast to private practice, all bills are collected in full.

No doctor is required to practice under national health insurance. All have the right to practice privately and continue to collect private payments. However, only a few specialists in the principal cities can prosper in this way. All others take national health insurance practice as a matter of course.

Differences remain among doctors in their specialties, professional reputations, and hours of work. Therefore, their incomes continue to differ. A few countries give additional financial awards, to persuade the most respected doctors to practice under national health insurance. All have some methods of investigating patterns of billing, in order to make sure that very large numbers are due to genuine productivity and are not fraudulent. These controls are exercised by doctors themselves, either serving on committees of the medical association or employed by the health insurance carriers.

WHAT DIFFERENCE WOULD IT MAKE TO HOSPITALS?

Countries with national health insurance confront the same problems as the United States in hospital affairs, viz., the hospitals absorb large proportions of the spending on health. All countries search for ways of making hospitals effective but not wasteful, but the need to control costs under national health insurance has made others' efforts more urgent and more effective.

Countries have not settled on any standard method of managing and paying for hospitals, comparable to the nearly universal practice of paying office doctors for ambulatory care under fee-for-service. Usually the owners

of hospitals are local rather than large nationwide agencies. In some countries, hospitals are owned by provincial or local governments. In other countries, private charitable associations own a large proportion of them. Throughout the world governments begin to plan and control new construction and the acquisition of new machinery, on the grounds that it is the governments that pay for the buildings and equipment. Often the national government leads the planning.

Countries are experimenting with various methods of paying for hospital operating costs. Many have government agencies that inspect and approve hospital operating budgets for the next year. In a few countries, hospital insurance is paid out of public funds, and governments pay operating costs in full. Where insurance carriers exist, they pay operating costs for their subscribers' inpatient or outpatient care, and the provincial, national, or local government pays the rest of the operating costs.

Several states in the United States have been experimenting with hospital rate-setting commissions, somewhat like those abroad. But most of these efforts have been weak, often because they do not apply to all hospital bills. Enactment of national health insurance would make such rate review urgent in the United States, just as it would require Americans to adopt negotiated fee schedules for ambulatory care.

WHAT DIFFERENCE WOULD IT MAKE TO GOVERNMENT?

Since national health insurance does not create government agencies that employ doctors, it is not a conventional public program that shows up in government budgets. Rather, it is administered by an "autonomous" sector, such as health insurance carriers, medical associations, and similar nongovernmental but public agencies in other areas of the social services.

These organizations act according to law; they receive payroll taxes levied on subscribers and employers, much like the premiums in the pre-existing private insurance; and they pay benefits.

Some Americans are worried that national health insurance will produce large deficits in government budgets. But it would do so only if Washington added many new benefits and changed the financing method. All transactions that now pass through many collectors and payers of money would pass through a single structure of payroll taxes, carriers, and payments according to fee schedules and rate schedules. If the law required the carriers to limit payments to their incomes from payroll taxes, large government subsidies from general revenue would not be necessary.

Some Americans fear that national health insurance will feed inflation in health costs. That would occur only if carriers and government were weak bargainers in the negotiations with doctors, hospitals, and drug companies. The organized structure of national health insurance provides decision points where costs can be checked, in contrast to the present amorphous situation in the United States. The proportion of Gross National Product now going into health care in the United States (about 9%) is one of the highest in the world. During the 1970's--except for two years of wage and price freezes--the proportion rose faster in the United States than in any country with national health insurance. Canada and Germany demonstrate the possible savings from strictly administered national health insurance: during recent years, the proportions of their GNP's spent on health have remained almost the same, and occasionally in Canada the figure has dropped.

WHAT DIFFERENCE WOULD IT MAKE FOR INSURANCE CARRIERS?

An important change under national health insurance is the growing independence and importance of the carriers. The nonprofit private health

insurance funds continue under national health insurance, as official carriers. Their previously private premiums are converted into payroll taxes, levied on subscribers and (usually) on their employers. These taxes become part of the flow of social security money from subscribers and employers to the providers of services.

The carriers become watchdogs of the system. They bargain with medical associations over contracts and fee schedules. They argue for lower rates before the agencies that decide payments to hospitals. They speak for subscribers in demanding adequate performance from doctors and hospitals.

Blue Cross and Blue Shield would probably merge and become the carriers under national health insurance, if the United States follows foreign precedents. The for-profit insurance companies might not play a role; abroad, the work is legally confined to the nonprofit carriers, or the private companies find health unprofitable. The Blues would have to develop their foreign counterparts' style of adversarial bargaining with providers; therefore they would have to exclude representatives of the doctors and of hospitals from their governing boards.

WHAT DIFFERENCE WOULD IT MAKE TO SOCIETY?

Since national health insurance is a structure for administering payments and benefits, its most important result for the United States would be requiring Americans to develop policies and make decisions. For some time, the United States has drifted in many of its social services: it has spent large amounts of public and private money in channels not fully understood with results not adequately evaluated. Americans view their health services with a mixture of faith and resentment, a mixture of awe and complaint. As in other countries, businessmen protest the heavy costs they bear for

employees' health benefits and are beginning to call for restraint. Enacting national health insurance in America would lead to a more focussed debate about the benefits of health services and about control over waste and over profiteering. It would also make more urgent the improvement of the uneven administrative capacities of the national, state, and local governments.

THE FUTURE

Despite the confusion over health policy in America today, all the foregoing trends can be discerned. Having promised the medical profession to pay "reasonable charges" for many years and having seen medical fees skyrocket, the Health Care Financing Administration is now gingerly approaching a recommendation for negotiated fee schedules under Medicare and Medicaid. Several states are planning stronger rate reviews of hospitals, and the Carter Administration favors price controls. The American Medical Association is training its national and state officials in methods of negotiation. Blue Cross and Blue Shield are reducing the representation of doctors and hospitals on their boards and are becoming more strict in bargaining with medical associations and hospitals.

National health insurance will not be the final form of organizing health financing. The demographic trends of developed countries foreshadow problems in its ultimate viability. It is not conventional insurance, with benefits paid from the subscriber's investment, but (like all social security) it is a pay-as-you-go system: current subscribers, employers, and taxpayers pay for the bills of current patients. In all developed countries, the retired and the invalids (who are heavy users of health care) are increasing at a faster rate than the wage-earners (who pay premiums and taxes). Several

European countries--Germany, France, and Switzerland--are far along in these trends, and their health insurance accounts are seriously strained. During the late 1970's, policy-makers were engaged in desperate patchwork to restrain rising costs and to subsidize the accounts. Eventally, most countries will need to change from premiums to general revenue payments into the insurance accounts (as in most of Canada) or replace insurance by a national health service (as in Great Britain and Sweden). Ultimately policy-makers in the United States and elsewhere will have to face the hardest of all choices in a utopian field, how to ration services to the "needy." If Americans can make their difficult decision to introduce national health insurance during the coming years, they will be buying time, with even harder choices ahead. But meanwhile, they will have created a system for identifying the problems and for making decisions. And that can be the most valuable lesson the United States can learn from abroad.

* * * * * * * * * *

I have elaborated many (but not all) of the foregoing points in my publications:

Paying the Doctor: Systems of Remuneration and their Effects (Baltimore: The Johns Hopkins Press, 1970).

Health Insurance Bargaining: Foreign Lessons for Americans (New York: Gardner Press and John Wiley, 1978).

The Doctor under National Health Insurance: Foreign Lessons for the United States. A report to the Office of Research and Statistics, Social Security Administration, 1977. Available from the National Technical Information Service, Springfield, Virginia; and from the National Health Planning Information Center, Hyattsville, Maryland.

"Socialized Medicine in Practice," The Public Interest, Volume 1, Number 3 (Winter 1966), pp. 90-106.

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PROGRAMS IN HEALTH
AND GERONTOLOGICAL
SERVICES ADMINISTRATION

FINANCIAL DECISIONS IN EUROPEAN HEALTH INSURANCE

Lessons for the United States

by William A. Glaser

July 1988

This project was supported by Grant Number HS05255 from the National Center for Health Services Research and Health Care Technology Assessment.

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EXECUTIVE SUMMARY

The American approach to health insurance is deteriorating. Nearly the entire population was supposed to be covered by insurance provided by employers as a fringe benefit. The elderly and poor were to receive mainstream care through special programs. Everyone would receive generous medical benefits, with modest cost-sharing.

However, as industrial employment recently declined, as many people became unemployed or irregularly employed, and as many obtained jobs in small business, many workers now lack health insurance. Even if they are covered by an employee group, many of their dependents are not, since they have to pay premiums. Even if a worker and his dependents remain members of a group, the benefits might be reduced to limit the costs of the employer and of the insurance carrier. In order to limit their budget deficits, the national and state governments at times have reduced enrollment in Medicaid. As the national government tried to control reimbursement to providers, Medicare has become more contentious.

The mosaic of private and public financing arrangements was supposed to be the American alternative to the universal statutory arrangements -- whether national health insurance or a national health service -- that all other developed countries have established. Making health insurance part of obligatory social security would be unnecessary, and the United States would continue to enjoy free choice, competition, and flexibility. However, Washington and the private sector are now discussing the magnitude of unmet needs, and soon the feasibility of statutory health insurance will again be seriously debated. Several study groups have begun to design proposals.

The purpose of this research project is to describe how statutory health insurance abroad deals with the financing problems that beset the United States today. Other countries have faced America's difficulties and have adopted several forms of obligatory insurance. An excellent way to understand the American situation more deeply, to design possible remedies, and to anticipate difficulties is to examine these other systems. The American social security system was enacted in the 1930's after decades of discussion of European precedents and after the private pension arrangements were nearly wiped out by the Depression. The same outcome might finally occur in health, the only gap remaining in American duplication of European social security.

RESEARCH QUESTIONS

Following are the principal topics in the research. Each is one of the areas of difficulty in American health care financing at present. For each, I describe the principal solutions adopted by European statutory health insurance schemes. For each mechanism, I sketch drawbacks as well as achievements.

General character. Is statutory health insurance closer to private insurance or to social security? How free are individuals to decide whether to be covered, the extent of their benefits, the size of their premiums? If expected to enrol, can they opt out and save their money? Can the carriers become the victims of adverse selection? Can the carriers protect their financial balance by preferred-risk selection? Are overpayers-and-underusers rewarded? Are underpayers-and-overusers penalized?

Structure. Are the health insurance carriers government agencies or private organizations? What are the advantages and disadvantages of each form? Are the carriers few or many? If they are many, are they organized into a structure? Are the private carriers nonprofit or for-profit? If the carriers are private, how do they relate to the larger social security structure and to government?

Coverage and access. Are the elderly and poor required to join the general scheme? If so, how are their premiums paid and how are their costs covered? In benefits and status, do they differ from the economically active?

Can certain occupations and the rich stay out of the obligatory system? What do they do in practice -- join voluntarily, self-insure, or buy private insurance? If they stay out, do financing problems result for the general scheme?

How are dependents covered?

Do certain occupations join the general scheme only with special advantageous arrangements? What are the consequences for the administration and financing of the system?

Payroll taxes. What are the possible arrangements: flat rate or progressive; equal upon worker and employer or heavier on employer; with and without an earnings ceiling; with and without variations among occupations and geographical regions? Why does a country adopt its arrangement? How does it decide the rates? What are the roles of government and the carriers? How are the health insurance rates connected to the other social security payroll taxes?

Does the payroll tax have disadvantages, such as regressive incidence, adverse effects on employment, and adverse effects on exports? Should it be supplemental or replaced by other taxes, such as proportionate or progressive taxes on income or taxes on added-value?

Premiums. Why does a country use premiums instead of payroll taxes? For the alternative types -- community, age-graduated, level age-of-entry -- what are the arguments for and against each, what situations make each feasible or difficult? Why does a country adopt one or a mixture? How are rates

decided? What are the roles of government and the carriers? Are there variations among carriers, geographical regions, occupations, individual health risks, and subscriber income groups? Can a subscriber choose lower premiums for lower benefits?

Group contracts. Do any employer-based groups exist under statutory health insurance? Can they survive as a vehicle for supplementary private insurance?

Subsidies by government. For what purposes are they provided: keep payroll taxes on employers low, cover costs of the elderly, cover the costs of the unemployed, or pay for particular benefits? Should subsidies be earmarked for particular purposes or should they go into the carriers' general funds? Should subsidies go to some or all carriers? How do governments decide about the purposes and sizes of subsidies? Are formulae used?

Should there be auditing requirements and program conditions, in return for subsidies?

Transfers among funds. For what reasons are shortfalls in one sickness fund alleviated by interfund equalization payments, instead of by government subsidies: limit deficits in the government's general budget; manage a social security system with several sickness funds as if it were unified; correct the effects of preferred-risk selection among funds; correct the financially perverse effects of compulsory assignment rules? Do transfers undermine incentives for carriers to keep clear-cut accounts and to be efficient?

Should transfers be calculated according to the carriers' demographic characteristics, member incomes, or medical care costs?

Cost containment. Under what conditions do countries employ one or more of the following methods: shift some of the costs to the patient; limit total resources going into health; limit unit prices of services; limit volume of services; reward patients for pressing providers to become more economical; and limit the total amount of cash? What are the achievements and failures of each method?

Adding acute-care benefits. How are new benefits added to insurance coverage; how are obsolete benefits dropped? What roles do the doctors, the sickness funds, and the government play in the decisions? How do the providers and the insurance carriers manage patient demand and patient entitlements that outrun available provider capacity?

Long-term care. Are these benefits being added to obligatory health insurance, like traditional acute-care benefits? Are the same forms of payroll taxes or premiums used? Do sickness

funds or other agencies administer enrollments, the money, and provider claims?

Are special forms of obligatory/universal or voluntary insurance used? Are benefits payment-in-full for services or are they indemnity cash payments? Does government subsidize some or all patients?

Does long-term care have any connection to the pension system?

RESEARCH METHODS

The principal method was extensive interviews in health insurance carriers, social security programs, and governments in the principal European countries with statutory health insurance, viz., France, West Germany, The Netherlands, Belgium, and Switzerland. The field work lasted one or two months in each country. The interviews with informants were systematic, qualitative, and often very long, rather than the administration of fixed-answer questionnaires distributed among a sample. Informants were asked about their own work and the operations of their agencies. The goal is always to interview enough significant people -- each in a special area -- to draw reliable conclusions about the principal topics in the research project.

Shorter periods of field work were conducted in Spain, Italy, and Great Britain to learn about the evolution of statutory health insurance in the past and to learn about the present role of private supplementary health insurance in systems that have evolved into national health services.

Files and documents were also examined. In several countries, particularly France, the literature about social security and health insurance is voluminous.

Additional perspectives and facts came from my previous research in these countries, where I have studied the payment of doctors, the payment of hospitals, and national-provincial relations in health.

SOME EMPIRICAL GENERALIZATIONS

General character. Statutory health insurance regularizes and makes obligatory the pre-existing voluntary social insurance system. The carriers, providers, and methods of reimbursement are retained. The statute makes membership more extensive and obligatory, requires all participants to pay payroll taxes or premiums, and specifies minimum benefits.

Statutory health insurance is part of the country's social security system. It embodies the philosophy of social solidarity

by overcharging the healthy, in order to support the less affluent and the less healthy. Health insurance becomes one of the islands of social solidarity, equality, and financial redistribution in countries that preserve private ownership, competition, and self-interest in other markets.

Voluntary supplementary insurance survives in countries with statutory health insurance. These arrangements are based on true insurance principles, rather than social solidarity and pay-as-you-go.

Every law enacted by a democratic legislature is shaped by pressures. Therefore, some groups secure lower payments and higher benefits than might be expected by the canons of social solidarity and equality of results.

Structures. The pre-existing health insurance carriers usually become the official financial agencies under the law. Usually they are the mutual aid funds and the nonprofit insurance carriers that have existed for centuries. The character of the funds and the structure of the system vary among countries. In some, the separate sickness funds eventually unify voluntarily. In others, they are replaced in the principal insurance work by autonomous public corporations, but they survive as voluntary carriers for supplementary benefits.

The individual sickness funds of the same character -- for example, representing the same occupation or the same religious group -- join in national and (in federal systems) provincial associations. The national and provincial offices have considerable importance in dealing with government and in negotiating with providers.

Because of the preservation of pre-existing carriers and because of the militancy of certain social groups, the structure of statutory health insurance often is very complicated. The relation to the rest of the social security system varies among countries and usually is complicated too.

Sickness funds are usually democratically run associations, with governing boards representing subscribers and payers.

Some countries have special councils to bridge relations between the sickness funds and government, to monitor the performance of the health insurance sector, and to manage relations between carriers and providers.

Private commercial health insurance companies are not mainstream carriers but occupy small special niches in the market. Usually they offer a range of policies which -- like auto accident insurance and life insurance -- are more profitable and simpler than the health line.

Coverage and access. Statutory and obligatory health insurance began in every country among industrial workers. Other occupations were added from time to time. In several countries now, coverage and access to mainstream medicine are universal.

If the entire population is not required to participate in the statutory program, the persons left out are the upper classes, not the poor. The rich obtain full coverage under private health insurance.

In order to force or persuade some occupations to join the universal scheme -- such as the self-employed and farmers -- they are often conceded lower premiums and lower cost-sharing.

The elderly and unemployed once were carried free, but now they are expected to pay special low premiums.

Those who are required to join may automatically be assigned to particular sickness funds for their occupation or region. In some countries, subscribers can choose sickness funds and the carriers compete for enrollments. The funds attract members through ideological appeal or by offering better benefits, rarely by offering lower premiums.

However, in private voluntary insurance markets, carriers often compete by offering lower premiums. But then they must avoid bad risks, an option rarely available to the social insurance carriers.

Payroll taxes. In most countries, employers pay a higher percentage than employees. But the rates are equal in some countries.

In order to raise more revenue to cover rapidly mounting health costs, governments now avoid increasing the payroll tax rates but increase or eliminate the earnings ceilings.

Usually the payroll tax rates are Acts of Parliament, standard throughout the country. However, Germany allows every sickness fund to set its own rates according to its costs and fiscal capacity. Rates then vary across the country and among carriers.

Where the rates are Acts of Parliament, they must be decided -- along with all other social security taxes -- at the highest ranks of government.

In order to increase revenue, there are proposals to expand the taxable base from work earnings to all income. Such a policy has not been adopted permanently, since it would change the character of social security and increase the power of the administrators of the income tax system. Proposals to graduate the payroll tax rates have not been implemented, since they would

be too redistributive, too complicated, and too much like the income tax.

High rates on employers are thought to discourage employment, hurt exports, and create an underground economy. Governments try to avoid further increases and, if possible, reduce the rates on employers. But substitutes are difficult to find. Value-added taxes and other types of tax have adverse effects, as the payroll tax does. They may be more difficult to administer.

Complete fiscalization instead of the payroll tax system is proposed in theory but resisted in practice, since it would change the character of social security and change the fiscal burdens. Some governments that adopt a goal of fiscalization have had to retain payroll taxes in practice. A few countries earmark small special excise taxes for the sickness funds.

Premiums. A few countries -- particularly Switzerland -- use premiums rather than payroll taxes. They are levied by the sickness funds according to their own financial strategy and do not require government approval. They are paid by subscribers, and usually not by employers. Statutory health insurance in such arrangements is administered separately from social security.

Community rates spread standard rates across risks but are undermined by competition among carriers. Some companies offer low rates to the young. Then premiums rise with age and may vary by sex. Insurance underwriters require surcharges from poor risks and from workers in dangerous occupations.

In order to limit rate increases for the elderly, carriers in several countries use level age-of-entry premiums. These stabilize the market, since subscribers become locked into their original carriers.

If the law does not mandate minimum benefits and maximum cost-sharing, carriers compete by offering sliding scales; a subscriber pays lower premiums and buys less coverage. These options occur in private supplementary insurance but rarely in mainstream social insurance, since the system needs full payments from the better risks who would choose lower premiums.

Group contracts. Health insurance as a fringe benefit of employment exists in private supplementary insurance in only a few countries. It is common in second-tier private pensions.

Group health insurance is unnecessary in countries with statutory health insurance. Employer and worker pay health insurance payroll taxes to the social security collection system, and the worker receives standard coverage.

Subsidies by government. Some governments have subsidized sickness funds from the start of statutory health insurance,

either to build up their management capacity, to keep payroll taxes low, or to compensate for a politically motivated exemption of employers from health insurance payroll taxes. (In the latter case, the employers pay normal payroll taxes for the rest of social security.) The size of the subsidies, the payroll tax rates, and the financial state of health insurance become part of the annual budgetary decisions of the national government. As a condition for receiving and spending money from the general Treasury, the sickness funds are audited regularly by government.

As sickness fund membership aged and as health care costs rose, several governments began subsidizing the sickness funds to cover the pensioners and the poor. These quickly became the largest of all subsidies, straining government budgets and making health care cost containment a very urgent national policy priority.

In order to limit massive government participation in the finances of the supposedly autonomous sickness funds, some countries direct national and provincial subsidies into other channels, thereby preserving the private character of health insurance. Government may subsidize the investments and operating costs of hospitals, limiting their claims upon the sickness funds. Government may help the aged and the poor pay normal premiums to the sickness funds.

Transfers among funds. In countries where several sickness funds exist, where their membership compositions vary widely, and where the most affluent carriers practice preferred-risk selection, government enacts an equalization system. For government, it is an alternative to subsidies and strains on the public budgets. For the sickness funds, it is the price paid for resisting the unification that would pool all revenue and all risks. For the recipients of transfers, it is the reward for political skill.

An equalization system can be established more easily among governmental carriers than among private sickness funds. The latter try to keep their extra cash and use it to offer extra benefits and attract more low-risk members. Associations of sickness funds in the same sector may estabish voluntary transfer mechanisms of their own to save members from bankruptcy and to facilitate mergers.

If sickness funds vary widely in the affluence and risk compositions of their members, and if the differences result from preferred risk selection in a competitive market, the profitable carriers may agree to voluntary transfers to carriers with deficits, in order to head off legislation to reorganize the system.

Equalization systems are criticized for perverse incentives: a sickness fund management may waste money rather than be

efficient and save. If equalization is based on differentials in expenditure rather than differentials in revenue and in membership composition, the carrier has no incentive to contain the costs of health care providers.

Cost containment. Lest they run deficits, sickness funds are always supposed to be vigilant against excessive charging and utilization by providers. However, as coverage, utilization, and service intensity grew, sickness funds claimed they were victims of public policy and pressed governments for steadily higher payroll taxes and subsidies. Governments have become more intrusive in demanding that sickness funds drive hard bargains with providers, prevent wasteful overutilization, and keep spending within the fiscal capacity of the society.

The expansion of the hospital sector is now controlled, but capital limits cannot affect ambulatory care and most services by doctors.

Sickness funds have recently limited annual increases in fees of doctors, but the amounts had previously reached high levels. Regulators and sickness funds have limited annual increases in hospital rates, but the process has been very contentious. Costs in both ambulatory and intramural care continued to rise because mere price controls did not restrain utilization.

Various methods have been used to limit utilization, but these are very contentious. Sickness funds and government shrink from over-ruling the clinical decisions of doctors. Universal health insurance was originally intended to facilitate and not deny access and utilization.

Patient cost-sharing is routinely used to discourage wasteful utilization in some sectors, such as drugs. Large cost-sharing is now applied to discourage unnecessary use in clinically debatable sectors, such as thermal cures. But most patient cost-sharing in essential clinical services is too small to have significant effects, populations become accustomed to it, and long-term effects are minor.

A trend is to limit spending directly by granting large individual providers (like hospitals) or entire sectors fixed annual amounts ("global budgets"). Providers then decide the levels of utilization and the mix between practice costs and net income.

Adding acute-care benefits. Sickness funds and medical associations have standing committees that negotiate the fee schedule for doctors, and they become essential machinery in adding new benefits, dropping obsolete procedures, and reducing the financial rewards for procedures that become routine.

Elaborate new programs require considerable investment in buildings, machinery, and personnel, and they are added to

teaching and nonteaching hospitals according to the system of granting capital. The sickness funds may not participate in the making of grants.

If a country has a large council to govern health insurance, it decides whether to add new benefits in all sectors of health. The sickness funds and other interest groups participate in these decisions.

When a program is licensed and included in fee schedules, the sickness funds are expected to pay for patient use. The entitlements of patients are unlimited, if doctors prescribe such care. If waiting lists result, the carriers may pay for care abroad.

Long-term care. Service delivery and financing methods are in flux abroad. Prolonged hospitalization in skilled nursing homes is usually covered under statutory health insurance. Many chronically ill elderly block acute-care and extended-care hospital beds, in lieu of long-term care programs.

Statutory long-term care insurance has been enacted only in Holland. It covers nursing homes and home care, and the country has many providers. Other countries are concerned with containing social security costs at the moment and shrink from enacting such an unpredictable and potentially expensive program.

Mixed financing is becoming common in home care. The social security pension institute may subsidize the creation of providers and the patients' daily costs. Local welfare programs of government help pay services to the poor elderly.

A few private health insurance companies are beginning to offer long-term care insurance. Usually the benefits are cash indemnities.

LESSONS FOR THE UNITED STATES

After each topic in the report, the chapter concludes with some strengths and weaknesses of European methods, for the guidance of statutory acute-care health insurance in the United States. The final chapter summarizes how such a program might be designed in the United States. America solved its pension problems a half-century ago by copying European precedents, and a close copy of European health insurance might be the simplest and least troublesome method. The favorite American statutory reform -- mandating more extensive employer group coverage -- would be complicated, contentious, and incomplete in both coverage and benefits, as the text explains.

A more typical statutory health insurance system would simply require that every covered person enrolls in a health

insurance carrier, that all employers, covered workers, and self-employed persons pay payroll taxes on earnings, and that the revenue go to the carriers. All existing carriers could continue under the official scheme, offering the minimum benefits and adding supplementary benefits from their unspent income and from additional voluntary policies. Hospitals, doctors, and other providers would continue to be private and autonomous, as at present, but all-payer rate negotiations would take place between associations of insurers and of providers. The elderly and the poor would continue membership in their insurance carriers, and the present series of troubled categorical programs (such as Medicare and Medicaid) would be abolished. Government might subsidize the insurance carriers, instead of paying for Medicare and Medicaid. The carriers would be the watchdogs over costs, since they would have to help pay rates and utilization within their budgets, determined by revenue from the payroll taxes and public subsidies. American government, providers, and carriers would have to collaborate in creating policies about access, benefits, costs, and forms of service delivery -- in contrast to the present customs of drift, contention, and waste.

In contrast to statutory acute-care health insurance, there is no simple and standard European model of long-term care insurance to provide Americans either with creative inspiration or a direct copy. The United States and Europe can share ideas during the coming years as they design services and financing methods for tasks that they must face together.

WILLIAM A. GLASER

Autumn 1986

1. General Information:

   a. Addresses:
      1) Business: Department of Health Services Administration, Graduate School of Management and Urban Professions, New School for Social Research, 66 Fifth Avenue, New York, New York 10011. Telephone: (212) 741-8689 or 741-8684

      2) Home: 54 Morningside Drive, New York, New York 10025. Telephone: (212) 749-1052

   b. Born 4 December 1925. Married, three children. U.S. citizen.

   c. Education:
      1) B.A., New York University, 1948

      2) M.A. and Ph.D. in Political Science, Harvard University, 1949 and 1952.

2. Teaching Experience:

   a. Assistant professor and instructor in Department of Social Science, Michigan State University, East Lansing, Michigan. September 1952-June 1956.

   b. Professor in the Department of Health Services Administration and Gerontological Services Administration, Graduate School of Management and Urban Professions, New School for Social Research, New York, July 1982 et seq. (currently employed).

   c. Adjunct Professor, School of Public Health, Columbia University, New York, 1982.

3. Research Experience:

   a. Columbia University. Senior Research Associate and Research Associate, 1956-1982. Affiliated with the Bureau of Applied Social Research and Center for the Social Sciences. Directed the following research projects:

      1) Regional Panels Project. Voting behavior study sponsored by the American Association of Public Opinion Research and supported by the Rockefeller Foundation. My participation supported by a research training fellowship from the Social Science Research Council.

2) Flow of Information among Natural Scientists. A study in communications and in the sociology of science. Supported by the National Science Foundation.

3) Studies in the Sociology of Medical Education. Study of the socialization process by which medical students acquire the attitudes and skills of doctors. Supported by the Commonwealth Fund, Western Reserve School of Medicine, Cornell University School of Medicine.

4) Public Health Nursing Study. Analysis of the contributions made by public health field experience in the professional development of student nurses. Supported by the Rockefeller Foundation and conducted at the Cornell University-New York Hospital of Nursing.

5) Cross-National Study of Health Institutions. Study of how differences in the social environment produce international variations in the medical profession, nursing, and hospital organizations. Supported by the National Institutes of Health, the Bureau of State Services of the U.S. Public Health Service, the Rockefeller Foundation, the Russell Sage Foundation, and the Health Information Foundation.

6) International Survey of Sheltered Employment. Survey by mail of the special workshops for the disabled throughout the world. Supported by a grant by the Easter Seals Research Foundation to the International Society for Rehabilitation of the Disabled.

7) Pretrial Discovery and the Adversary System. Evaluation of the effects of the pretrial discovery rules on civil litigation in the United States District Courts. A report was submitted to the Advisory Committee on Civil Rules, Judicial Conference of the United States. Supported by grants from the Ford Foundation, the Walter E. Meyer Research Institute of Law, and the Russell Sage Foundation.

8) Comparative Study of Factory Organizations. Collaboration with four European research centers to plan field survey of factories, write theoretical essays in industrial sociology, reanalyze research reports about industry in many countries. Supported by a grant from the National Science Foundation.

9) The Brain Drain. Survey of students and professional persons in twenty countries. Collaboration with survey research centers throughout the world and also with the United Nations Institute for Training and Research. Supported by grants from the Ford Foundation, the Agency for International Development, the National Science Foundation, and the governments of participating countries.

10) Social Relations in Technical Assistance. Study of interaction between foreign experts and host country counterparts. Collaboration with research centers in Colombia, Nigeria, and Nepal. Contract with Agency for International Development.

11) The Doctor under National Health Insurance: Foreign Lessons for the United States. Interviewing and review of literature in eight industrial countries. Supported by Social Security Administration.

12) Federal-provincial relations, with special reference to health services. Comparisons of Canada and West Germany, with lessons for the United States. Supported by grant from the National Center for Health Services Research, United States Department of Health, Education and Welfare.

13) Paying the Hospital. How the leading developed countries determine the rates and budgets of hospitals: Germany, France, Holland, Switzerland, Canada, United Kingdom. Lessons for paying the hospitals of the United States. Supported by the Health Care Financing Administration, Department of Health and Human Services.

b. New School for Social Research:
Financial Decisions in European Health Insurance. Organization and financing of statutory health insurance in Germany, France, Holland, Switzerland, and Belgium. Additional information from Spain, Italy, and England. Lessons for organizing statutory health insurance in the United States. Supported by National Center for Health Services Research, United States Department of Health and Human Services.

c. Executive Director, Council of Social Science Data Archives, 1965-1968. The Council was an association of data archives, social research centers, and computer centers interested in the social sciences. By 1968, twenty-eight universities and non-profit organizations were members. The work of the Council was supported by grants from the National Science Foundation.

4. Publications:

a. Books written:

1) National Health Insurance in Practice, in progress during 1986.

2) Paying the Hospital (San Francisco: Jossey Bass, Inc., 1987).

3) Health Insurance Bargaining: Foreign Lessons for Americans (New York: Gardner Press and John Wiley, 1978).

4) The Brain Drain: Migration and Return (with Christopher Habers) (Oxford and New York: Pergamon Press, 1978)

5) Paying the Doctor: Systems of Compensation and Their Effects (Baltimore: The Johns Hopkins Press, 1970). Portions reprinted in Hospital Times, Volume 1, 11 September 1970, pp. 4-5; GP, Volume 6, 18 September 1970, pp. 16-17; and The Community Health Centre in Canada--Report of the Community Health Centre Project to the Health Ministers (Ottawa: Queen's Printer, 1972), Volume 3, Chapter 7, pp. 9-14 and 18-19.

6) Social Settings and Medical Organization: A Cross-National Study of the Hospital (New York: Atherton Press, 1970).

7) Pretrial Discovery and the Adversary System (New York: Russell Sage Foundation, 1968). Portions reprinted in James H. Chadbourn and others, Civil Procedure: Cases and Materials (Mineola, N.Y.: The Foundation Press, 1974), pp. 374-377, 383, and 543-550.

8) Public Opinion and Congressional Elections (with William McPhee and others) (New York: The Free Press, 1962). Chapter 9 reprinted as "Les mécanismes de la participation électorale," in François Chazel et al. (editors), L'analyse des processus sociaux (Paris: Mouton, 1970), pp. 221-231.

b. Books edited:

1) The Government of Associations (co-editor with David Sills) (Totowa, N.J.: The Bedminster Press, 1966).

2) Readings in Social Science (co-editor with Douglas Dunham and others) (East Lansing: Michigan State University Press, First edition, 1956), Volume III. Glaser contributed one article.

c. Monographs:

1) Paying the Hospital: Foreign Lessons for the United States (New York: Center for the Social Sciences, Columbia University, 1982; issued jointly with the Health Care Financing Administration, Department of Health and Human Services, Washington).

2) A series of book-length reports about payment of hospitals in Switzerland, The Netherlands, France, Canada and Great Britain (New York: Center for the Social Sciences, Columbia University, 1980 and 1981).

3) Federalism in Canada and West Germany: Lessons for the United States (New York: Center for the Social Sciences, Columbia University, 1979).

4) The Doctor under National Health Insurance: Foreign Lessons for the United States (New York: Bureau of Applied Social Research, Columbia University, 1977; issued jointly with the Social Security Administration, Department of Health and Human Services, Washington).

5) The Migration and Return of Professionals (New York: Bureau of Applied Social Research, 1973; issued jointly with the Agency for International Development, Washington).

6) Outflow of Trained Personnel from Developing to Developed Countries: Report by the Executive Director of the United Nations Institute for Training and Research (New York: Economic and Social Council, The United Nations, Fiftieth Session, Agenda Item 3, 9 February 1971, Document E/4948, in four languages).

7) Sheltered Employment of the Disabled: An International Survey (Geneva: International Labour Office, 1967; also Stockholm: National Labour Market Board, 1966).

8) Three Papers on the Integrated Bar (New York: Bureau of Applied Social Research and the New York State Bar Association, 1960). Some of this is reprinted in Vern Countryman (editor), The Lawyer in Modern Society (Boston: Little Brown and Company, 1966), pp. 348-355.

9) Health and Diplomacy (New York: Research Institute for the Study of Man, 1963).

10) A Harlem Almanac (New York: Bureau of Applied Social Research, 1964).

11) Social Science Data Archives in the United States 1967 (New York: Council of Social Science Data Archives, 1967).

d. Articles:

1) Migration:

a. "International Flows of Talent," in Roy Bryce-Laporte (editor), Sourcebook on The New Immigration (New Brunswick: Transaction Books, 1980), pp. 59-68.

b. "Results of the Work of the United Nations Institute for Training and Research," in The "Brain Drain" Problem: Outflow of Trained Personnel from Developing to Developed Countries--Report of the Secretary General (New York and Geneva: Economic and Social Council, The United Nations, Agenda Item 21, 9 June 1978, Document E/1978/92), pp. 16-23.

c. "Migration of Talent," International Encyclopedia of Higher Education (San Francisco: Jossey-Bass Inc., 1977), Volume 6, pp. 2731-2741.

d. "The Migration and Return of Professionals," International Migration Review, Volume 8, Summer 1974, pp. 227-244.

e. "The Brain Drain and UNITAR's Multinational Research Project on the Subject," Social Science Information, Volume XII, April 1973, pp. 123-138 (with Mehri Hekmati).

f. "The Brain Drain: What We Know and Need to Know," in A.B. Zahlan (editor), The Arab Brain Drain (London: Ithaca Press, 1981), pp. 231-244. Also published in Arabic.

2) Cross-national studies of organizations:

a. "Cross-National Comparisons of Factories," Journal of Comparative Administration, Volume 3, May 1971, pp. 83-118. Reprinted as "Der Industriebetrieb im interkulturellen Vergleich," Soziale Welt, Volume 23, 1972, pp. 293-318. German text reprinted in Lutz Zündorf (editor), Industrie-und Betriebssoziologie (Darmstadt: Wissenschaftliche Buchgesellschaft, 1979), pp. 303-345.

b. "Cross-National Comparisons of Organizations," International Studies of Management and Organization, Volume V, Spring 1975, pp. 68-90.

3) Cross-national studies of hospitals:

a. "Paying the Hospital: Foreign Lessons for the United States", Health Care Financing Review, Volume 4, Number 4 (Summer 1983), pp. 99-110.

b. "Krankenhauskosten im internationalen Vergleich", in Christian von Ferber et al. (editors), Kosten und Effizienz im Gesundheitswesen (München: R. Oldenbourg Verlag, 1985), pp. 221-247.

c. "For-Profit Hospitals--American and Foreign Comparisons", Health Care Management Review, Volume 9, Number 4 (Fall 1984), pp. 27-34.

d. "Juggling Multiple Payers", American Problems and Foreign Solutions, Inquiry, Volume XXI, Number 2 (Summer 1984), pp. 178-188.

e. "Hospital Rate Regulation -- American and Foreign Comparisons", Journal of Health Politics, Policy and Law, Volume 8, Number 4 (Winter 1984), pp. 702-731.

f. "American and Foreign Hospitals: Some Sociological Comparisons", in Eliot Freidson (editor), The Hospital in Modern Society (New York: The Free Press, 1963), pp. 37-72.

g. "The Problems of the Hospital Administrator: Some American and Foreign Comparisons", Hospital Administration, Volume 9, Summer 1964, pp. 6-22.

h. "Nursing Leadership and Policies: Some Cross-National Comparisons", in Fred Davis (editor), The Nursing Profession (New York: John Wiley and Sons, 1966), pp. 1-59.

i. "Paying the Hospital in the United States" in the Proceedings of the Workshop on Hospital Financing Systems (Copenhagen: World Health Organization Regional Office for Europe, 1986).

4) Cross-national studies of health insurance and health services:

a. "Health Politics: Lessons from Abroad", in Theodor J. Litman and Leonard S. Robins (editors), Health Politics, Policy and the Public Interest (New York: John Wiley and Sons, 1984), pp. 305-339.

b. "Lessons from Germany," Journal of Health Politics, Policy and Law, Volume 8, Number 2 (Summer 1983), pp. 352-364.

c. American Health Care Problems and Foreign Solutions," in International Perspective on Health Care: Learning from Other Nations, Hearings held on 1 May 1984 (Washington: U.S. Government Printing Office, Comm. Pub. No. 98-450, 1984), pp. 4-16.

d. "Long-Term Care: American Problems and Foreign Solutions," in Continuing Care: International Prototypes for America's Aged, Hearings held on 15 July 1985 (Washington: U.S. Government Printing Office, Comm. Pub. No. 99-523, 1-85), pp. 189-215.

e. "Canadian Health Care Problems and Foreign Solutions", in the Proceedings of the Colloquium on Health Care Issues (Ottawa: Economic Council of Canada, 1986).

f. "Payment Systems and Their Effects," in Linda Aiken and David Mechanic (editors), Applications of Social Science to Clinical Medicine and Health Policy (New Brunswick: Rutgers University Press, 1986), pp. 481-499.

g. "Paying Physicians for Geriatric Care: The Experience Abroad," in Proceedings of the Conference on Paying Physicians for Geriatric Care (Washington: National Center for Health Services Research, 1986).

h. "Services for the Aged: Foreign Lessons for the United States" in Aging: An International Perspective -- Proceedings of a Conference (New York: Brookdale Institute on Aging and Adult Human Development and the School of International and Public Affairs, Columbia University, 1982), pp. 60-63.

i. "Politics of Cost Control Abroad," Bulletin of the New York Academy of Medicine, Second Series, Volume 56, Number 1 (January-February 1980), pp. 107-114.

j. "What Can We Expect from National Health Insurance?" Columbia: The Magazine of Columbia University, Volume 4, Winter 1978, pp. 31-33. Also published as "National Health Insurance in Practice" in National Conference of State Legislatures, State Innovations in Health (Washington: Intergovernmental Health Policy Project, George Washington University, 1980), pp. 61-64.

k. "National Health Insurance in Federal Systems," The State Perspective on Health Policy: The Report of the Health Policy Consortium (Phase 3) (Washington: Center for Policy Research, National Governors' Association, 1979), pp. 137-150.

l. "Controlling Costs through Methods of Paying Doctors: Experiences from Abroad," in Stuart O. Schweitzer (editor), Policies for the Containment of Health Care Costs and Expenditures (Washington: U.S. Government Printing Office, 1978, DHEW Publication No. (NIH) 78-184, pp. 209-241.

m. "Improving Federalism in American Health Services: Some Ideas from Abroad," in Christa Altenstetter (editor), Changing National-Subnational Relations in Health: Opportunities and Constraints (Washington: U.S. Government Printing Office, 1978, DHEW Publication No. (NIH) 78-182), pp. 389-399.

n. "Socialized Medicine in Practice," The Public Interest, Spring 1966, pp. 90-106. Reprinted in: George S. Masannat (editor) Basic Issues in American Public Policy (Boston: Holbrook Press, 1970), pp. 271-289; Eliot Freidson and Judith Lorder (editors), Medical Men and Their Work (Chicago: Aldine-Atherton, 1972), pp. 65-81; and Ray H. Elling (editor), National Medical Care (New York: Atherton Press, 1970), pp. 38-59.

o. "Medical Care: Social Aspects," International Encyclopedia of the Social Sciences (New York: The Macmillan Company and the Free Press, 1968), Volume 10, pp. 93-100.

p. "From National Findings to Cross-National Generalizations," Transactions of the Fifth World Congress of Sociology, 1962 (Louvain: International Sociological Association, 1964), Volume IV, pp. 465-471.

q. "Medical Administration in Russia--Some Recent Impressions," The Lancet, 16 December 1961, pp. 1352-1354.

r. "International Survey of Sheltered Employment," International Rehabilitation Review, Volume 18, July 1967, pp. 17-18. Reprinted in Phoenix News, Volume 7, December 1967, pp. 7-8.

s. Contributing author to Mottram Torre (editor), Selection of Personnel for International Service (New York: World Federation for Mental Health, 1963).

5) Sociological analyses of the health professions in the United States:

a. "Doctors and Politics," The American Journal of Sociology, Volume LXVI, November 1960, pp. 230-245. Revised version published as "The Political Values and Behavior of Doctors," in Joseph R. Fiszman (editor), The American Political Arena (Boston: Little Brown and Company; First edition, 1962, pp. 487-499; Second edition, 1966, pp. 440-457). Condensed version published in Cahiers de Sociologie et de Démographie Médicales, Volume III, April-June 1963.

b. "Evaluation of Performance in Public Health Nursing," Nursing Research, Volume 10, Winter 1961, pp. 32-37 (With Frances McVey).

c. "Effects of Public Health Field Practice upon Career Preferences and Career Plans," Nursing Research, Volume 14, Winter 1965, pp. 61-65 (with Frances McVey).

d. "The Performance of Students in Public Health," Nursing Research, Volume 14, Spring 1965, pp. 138-142 (with Frances McVey and Molly Schirm).

e. "Internship Appointments of Medical Students," Administrative Science Quarterly, Volume 4, December 1959, pp. 337-356.

6) International technical assistance.

a. "Experts and Counterparts in Technical Assistance," in Krishna Kumar (editor), Bonds without Bondage: Explorations in Transcultural Cooperation (Honolulu: The University Press of Hawaii, 1979), pp. 207-225.

b. "Improving Communication in the Technical Cooperation Relationship," Focus: Technical Cooperation, 1975/3, pp. 10-14. A special section of the International Development Review, Volume XVII, 1975.

c. "Making Better Use of Technical Assistance Experts," Focus: Technical Cooperation, 1975/4, pp. 21-25.

7) Politics and Government:

a. "Television and Voting Turnout," The Public Opinion Quarterly, Volume 29, Spring 1965, pp. 73-86. Reprinted in Joyce Gelb and Marian Palley (editors), The Politics of Social Change (New York: Holt, Rinehart and Winston, Inc. 1971), pp. 209-222.

b. "Intention and Voting Turnout," The American Political Science Review, Volume LII, December 1958, pp. 1030-1040. Reprinted in Paul F. Lazarsfeld et al (editors), Continuities in the Language of Social Research (New York: The Free Press, 1972), pp. 367-375.

c. "The Family and Voting Turnout," The Public Opinion Quarterly, Volume 23, Winter 1959-1960, pp. 563-570.

d. "Job Mobility between Government and Other Social Structures," PROD (later called The American Behavioral Scientist), Volume III, November 1959, pp. 20-23.

e. "The Types and Uses of Political Theory," Social Research, Volume 22, Autumn 1955, pp. 275-296. Reprinted in James A. Gould and Vincent V. Thursby (editors), Contemporary Political Thought (New York: Holt, Rinehart and Winston, Inc., 1969), pp. 70-88; and in George S. Masannat and Thomas W. Madron (editors), The Political Arena (New York: Charles Scribner's Sons, 1969), pp. 44-56.

f. "The Semantics of the Cold War," The Public Opinion Quarterly, Volume 20, Winter 1956-1957, pp. 691-716. Reprinted in J. K. Zawodny (editor), Man and International Relations (San Francisco: Chandler Publishing Company, 1967), Volume I, pp. 675-688.

g. "Theories of Soviet Foreign Policy--A Classification of the Literature," World Affairs Quarterly, Volume 27, July 1956, pp. 128-152.

h. "Algie Martin Simons and Marxism in America," The Mississippi Valley Historical Review, Volume 41, December 1954, pp. 419-434.

i. "The Units of Political Action", The Southwestern Social Science Quarterly, Volume 35, June 1954, pp. 23-35.

j. "A.M. Simons: American Marxist," Institute of Social Studies Bulletin, Volume I, Summer 1952, pp. 66-67, 94.

8) Research methods:

a. "International Mail Surveys of Informants," Human Organization, Volume 25, Spring 1966, pp. 78-86.

b. "The Process of Cross-National Survey Research," in Alexander Szalai et al. (editors), Cross-National Comparative Survey Research: Theory and Practice (Oxford: Pergamon Press, 1977), pp. 403-436. Reprinted in part in Comparative Interdisciplinary Studies Section Bulletin, Volume 5, November 1975.

c. "Plans of the Council of Social Science Data Archives," Social Science Information, Volume 5, December 1966, pp. 71-96(with Ralph Bisco).

d. "Note on the work of the Council of Social Science Data Archives 1965-1968," Social Science Information, Volume 8, April 1969, pp. 159-176.

e. Editor-in-Chief and author of much of the contents of the quarterly news magazine, Comparative Research, 1978-1982.

f. Reports for clients of the Bureau of Applied Social Research, including about six papers for the Western Reserve University School of Medicine during 1958.

William A. Glaser
"Health Insurance"
Table of contents of a book now in preparation, November 1988

/ A report "Financial Decisions in European Health Insurance", was submitted to the National Center for Health Services Research. The final book will use some of those materials, recasting them, including much material about the USA. In the right hand column, the Roman numerals show the chapter #s in the report which form the nuclei of the book chapters /

Part	New chapter numbers in each Part	Using materials in "Fin Dec" Ch
	Introduction to the book: research methods, etc.	I
A	Structure of health insurance	
	1. Overview of contents of book	
	2. Philosophies. Meaning of health insurance	II
	3. Structure of systems and of insurance funds	III
B	Coverage and access	IV
C	Sources of finance	
	1. Payroll taxes	V
	2. Policy problems with payroll taxes	VI
	3. Premiums	VII
	4. Government subsidies	VIII
	5. Transfers among funds	IX
D.	Benefits	
	1. Doctors	
	2. Hospitals	
	3. Pharmaceutical drugs	
	4. Dentistry	
	5. Mental health	
	6. Possibly other benefits: e.g., prevention, disability	
	7. Adding new benefits	XI
	8. Long term care	XII
E.	Major design issues	
	1. Cost containment	X
	2. Trends, reorganization in several countries	
	3. Role of private health insurance in government-funded	

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PROGRAMS IN HEALTH
AND GERONTOLOGICAL
SERVICES ADMINISTRATION

20 December 1988

Professor Ronald Andersen
Center for Health Administration Studies
Graduate School of Business
University of Chicago
1101 East 58 Street
Chicago
Illinois 60637

Dear Ron:

Your letter of December 5 arrived today. So, I could not respond by December 15.

The letter pictures the appearance as a typical academic performance, wherein the author has written a paper in advance and circulates it. As I told Ms Chin several times and as I said to you, I cannot and will not write a special paper. I can talk informally about the research I have been doing about how health insurance works in Europe and North America, with lessons for the USA. Therefore, you can circulate to all interested persons the executive summary of my NCHSR report that I sent you earlier, copy enclosed. In addition, you can give everyone my earlier paper "National Health Insurance in Practice", which is still accurate; copy enclosed.

I will have some informal notes from which I can start talking,to make clear to the audience what statutory health insurance is, why the USA took a different turn, etc. A good idea is to give them the accompanying handout on legal size paper. Americans don't seem to understand the difference betwee statutory health insurance and an NHS, and I will have to say something about that.

But attendees should be encouraged to break in with spontaneous questions, since I can talk about any other aspects of comparative health services that interests them.

Enclosed is a CV. It is accurate up through late 1986, but it is still o.k. I have written a few things since then too. My social security number is 081-20-0967.

Best wishes,

Bill Glaser

William A. Glaser

UNIVERSITY OF CHICAGO
COMPTROLLER FORM NO. 34
2.5M · 4/85

CONSULTANT

CONSULTING AGREEMENT

under

Sponsor/Agency: DHHS------ Grant/Contract Number: 1-E10-AH)))42-01-5-2066
Principal Investigator: Ronald M. Andersen Budget Period: 10/1/88 - 9/30/89

between **THE UNIVERSITY OF CHICAGO** (the "University")

and

Name: William A. Glaser (the "Consultant") Address: 54 Morningside Drive
Social Security No.: 081 - 20 - 0967 New York, New York 10025
Affiliation: New ~~York~~ School of Social Research
New York

The Consultant shall provide the following services:

Workshop presentation 02/09/89

These services shall be provided at times and for periods mutually agreed upon by the Consultant and the Principal Investigator. This Agreement shall be effective from the date signed until ~~September 30, 1989~~ unless extended by mutual agreement or sooner terminated by either party upon 30 days written notice to the other party. The work shall be performed personally by the Consultant as an independent contractor, and not as an employee of the University, and by no other person (except for secretarial or other incidental services) without the prior written permission of the University.

In consideration of the provision of these services the Consultant shall be paid a consulting fee of $ ~~100~~ per day, which sum the Consultant represents is not greater than that which the Consultant normally receives for like services.

The Consultant will/~~will not~~ XXXXXX be reimbursed for travel expenses, including subsistence, in accordance with the current travel policies of the University.

The Consultant may submit a request for payment at intervals no more frequently than once each month. Such request shall detail the date(s) on which services were rendered and the amount claimed. The grant or contract number should appear on such a request. Expenses incidental to travel, if allowed, will be reimbursed on submission of a standard University Travel Voucher, which shall be supported with airline ticket(s) and hotel receipts.

Any work arising from services rendered under this Agreement shall not be published or otherwise disclosed without first consulting with the Principal Investigator.

The Consultant agrees that, during the period in which services are being rendered under this Agreement, any invention, improvement, or discovery made, conceived, or for the first time actually reduced to practice, which is directly related to the subject matter of these activities will be promptly brought to the attention of the University. The University shall determine rights to such inventions or discoveries, within the limits set by the policies of the University and the sponsor, if any.

APPROVED:
Harry L. Davis (Dean)

CONSULTANT:
William A. Glaser (Signature)
9 February 1989 (Date)

(Department)

THE UNIVERSITY OF CHICAGO: ORA
Chuck Hayes (Signature)
2/28/89 (Date)

To be completed by Principal Investigator:

I have determined that, to the best of my knowledge:

1) The services to be provided by the Consultant are essential to the work under the referenced grant/contract and cannot be performed by persons otherwise compensated under this project or elsewhere employeed by the University.
2) The Consultant is judged by me to be the most qualified person available to provide these services.

Ronald Andersen (SIGNATURE) (DATE)

UNIVERSITY OF CHICAGO
COMPTROLLER FORM NO. 34
2.5M - 4/85

PRINCIPAL INVESTIGATOR

CONSULTING AGREEMENT

under

Sponsor/Agency: DHHS------ Grant/Contract Number: 1-E10-AH)))42-01-5-2066
Principal Investigator: Ronald M. Andersen Budget Period: 10/1/88 - 9/30/89

between **THE UNIVERSITY OF CHICAGO** (the "University")

and

Name: William A. Glaser (the "Consultant") Address: 54 Morningside Drive
Social Security No.: 081 - 20 - 0967 New York, New York 10025
Affiliation: New Xork School of Social Research
New York

The Consultant shall provide the following services:

Workshop presentation 02/09/89

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In consideration of the provision of these services the Consultant shall be paid a consulting fee of $ 100 per day, which sum the Consultant represents is not greater than that which the Consultant normally receives for like services.

The Consultant will/~~will not~~ XXXXXX be reimbursed for travel expenses, including subsistence, in accordance with the current travel policies of the University.

The Consultant may submit a request for payment at intervals no more frequently than once each month. Such request shall detail the date(s) on which services were rendered and the amount claimed. The grant or contract number should appear on such a request. Expenses incidental to travel, if allowed, will be reimbursed on submission of a standard University Travel Voucher, which shall be supported with airline ticket(s) and hotel receipts.

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APPROVED:

Harry L Davis (Dean) _____ (Department)

CONSULTANT: THE UNIVERSITY OF CHICAGO: ORA

William A. Glaser (Signature) Chuck Hagen (Signature)

9 February 1989 (Date) 2/23/89 (Date)

To be completed by Principal Investigator:

I have determined that, to the best of my knowledge:

1) The services to be provided by the Consultant are essential to the work under the referenced grant/contract and cannot be performed by persons otherwise compensated under this project or elsewhere employeed by the University.
2) The Consultant is judged by me to be the most qualified person available to provide these services.

Ronald Andersen (SIGNATURE) _____ (DATE)

File Thursday 2/8/89

WILLIAM A. GLASER

Autumn 1986

1. General Information:

   a. Addresses:
      1) Business: Department of Health Services Administration, Graduate School of Management and Urban Professions, New School for Social Research, 66 Fifth Avenue, New York, New York 10011. Telephone: (212) 741-8689 or 741-8684

      2) Home: 54 Morningside Drive, New York, New York 10025. Telephone: (212) 749-1052

   b. Born 4 December 1925. Married, three children. U.S. citizen.

   c. Education:
      1) B.A., New York University, 1948

      2) M.A. and Ph.D. in Political Science, Harvard University, 1949 and 1952.

2. Teaching Experience:

   a. Assistant professor and instructor in Department of Social Science, Michigan State University, East Lansing, Michigan. September 1952-June 1956.

   b. Professor in the Department of Health Services Administration and Gerontological Services Administration, Graduate School of Management and Urban Professions, New School for Social Research, New York, July 1982 et seq. (currently employed).

   c. Adjunct Professor, School of Public Health, Columbia University, New York, 1982.

3. Research Experience:

   a. Columbia University. Senior Research Associate and Research Associate, 1956-1982. Affiliated with the Bureau of Applied Social Research and Center for the Social Sciences. Directed the following research projects:

      1) Regional Panels Project. Voting behavior study sponsored by the American Association of Public Opinion Research and supported by the Rockefeller Foundation. My participation supported by a research training fellowship from the Social Science Research Council.

2) Flow of Information among Natural Scientists. A study in communications and in the sociology of science. Supported by the National Science Foundation.

3) Studies in the Sociology of Medical Education. Study of the socialization process by which medical students acquire the attitudes and skills of doctors. Supported by the Commonwealth Fund, Western Reserve School of Medicine, Cornell University School of Medicine.

4) Public Health Nursing Study. Analysis of the contributions made by public health field experience in the professional development of student nurses. Supported by the Rockefeller Foundation and conducted at the Cornell University-New York Hospital of Nursing.

5) Cross-National Study of Health Institutions. Study of how differences in the social environment produce international variations in the medical profession, nursing, and hospital organizations. Supported by the National Institutes of Health, the Bureau of State Services of the U.S. Public Health Service, the Rockefeller Foundation, the Russell Sage Foundation, and the Health Information Foundation.

6) International Survey of Sheltered Employment. Survey by mail of the special workshops for the disabled throughout the world. Supported by a grant by the Easter Seals Research Foundation to the International Society for Rehabilitation of the Disabled.

7) Pretrial Discovery and the Adversary System. Evaluation of the effects of the pretrial discovery rules on civil litigation in the United States District Courts. A report was submitted to the Advisory Committee on Civil Rules, Judicial Conference of the United States. Supported by grants from the Ford Foundation, the Walter E. Meyer Research Institute of Law, and the Russell Sage Foundation.

8) Comparative Study of Factory Organizations. Collaboration with four European research centers to plan field survey of factories, write theoretical essays in industrial sociology, reanalyze research reports about industry in many countries. Supported by a grant from the National Science Foundation.

9) The Brain Drain. Survey of students and professional persons in twenty countries. Collaboration with survey research centers throughout the world and also with the United Nations Institute for Training and Research. Supported by grants from the Ford Foundation, the Agency for International Development, the National Science Foundation, and the governments of participating countries.

10) Social Relations in Technical Assistance. Study of interaction between foreign experts and host country counterparts. Collaboration with research centers in Colombia, Nigeria, and Nepal. Contract with Agency for International Development.

11) The Doctor under National Health Insurance: Foreign Lessons for the United States. Interviewing and review of literature in eight industrial countries. Supported by Social Security Administration.

12) Federal-provincial relations, with special reference to health services. Comparisons of Canada and West Germany, with lessons for the United States. Supported by grant from the National Center for Health Services Research, United States Department of Health, Education and Welfare.

13) Paying the Hospital. How the leading developed countries determine the rates and budgets of hospitals: Germany, France, Holland, Switzerland, Canada, United Kingdom. Lessons for paying the hospitals of the United States. Supported by the Health Care Financing Administration, Department of Health and Human Services.

b. New School for Social Research:
Financial Decisions in European Health Insurance. Organization and financing of statutory health insurance in Germany, France, Holland, Switzerland, and Belgium. Additional information from Spain, Italy, and England. Lessons for organizing statutory health insurance in the United States. Supported by National Center for Health Services Research, United States Department of Health and Human Services.

c. Executive Director, Council of Social Science Data Archives, 1965-1968. The Council was an association of data archives, social research centers, and computer centers interested in the social sciences. By 1968, twenty-eight universities and non-profit organizations were members. The work of the Council was supported by grants from the National Science Foundation.

4. Publications:

a. Books written:

1) National Health Insurance in Practice, in progress during 1986.

2) Paying the Hospital (San Francisco: Jossey Bass, Inc., 1987).

3) Health Insurance Bargaining: Foreign Lessons for Americans (New York: Gardner Press and John Wiley, 1978).

4) The Brain Drain: Migration and Return (with Christopher Habers) (Oxford and New York: Pergamon Press, 1978)

5) Paying the Doctor: Systems of Compensation and Their Effects (Baltimore: The Johns Hopkins Press, 1970). Portions reprinted in Hospital Times, Volume 1, 11 September 1970, pp. 4-5; GP, Volume 6, 18 September 1970, pp. 16-17; and The Community Health Centre in Canada--Report of the Community Health Centre Project to the Health Ministers (Ottawa: Queen's Printer, 1972), Volume 3, Chapter 7, pp. 9-14 and 18-19.

6) Social Settings and Medical Organization: A Cross-National Study of the Hospital (New York: Atherton Press, 1970).

7) Pretrial Discovery and the Adversary System (New York: Russell Sage Foundation, 1968). Portions reprinted in James H. Chadbourn and others, Civil Procedure: Cases and Materials (Mineola, N.Y.: The Foundation Press, 1974), pp. 374-377, 383, and 543-550.

8) Public Opinion and Congressional Elections (with William McPhee and others) (New York: The Free Press, 1962). Chapter 9 reprinted as "Les mécanismes de la participation électorale," in François Chazel et al. (editors), L'analyse des processus sociaux (Paris: Mouton, 1970), pp. 221-231.

b. Books edited:

1) The Government of Associations (co-editor with David Sills) (Totowa, N.J.: The Bedminster Press, 1966).

2) Readings in Social Science (co-editor with Douglas Dunham and others) (East Lansing: Michigan State University Press, First edition, 1956), Volume III. Glaser contributed one article.

c. Monographs:

1) Paying the Hospital: Foreign Lessons for the United States (New York: Center for the Social Sciences, Columbia University, 1982; issued jointly with the Health Care Financing Administration, Department of Health and Human Services, Washington).

2) A series of book-length reports about payment of hospitals in Switzerland, The Netherlands, France, Canada and Great Britain (New York: Center for the Social Sciences, Columbia University, 1980 and 1981).

3) Federalism in Canada and West Germany: Lessons for the United States (New York: Center for the Social Sciences, Columbia University, 1979).

4) The Doctor under National Health Insurance: Foreign Lessons for the United States (New York: Bureau of Applied Social Research, Columbia University, 1977; issued jointly with the Social Security Administration, Department of Health and Human Services, Washington).

5) The Migration and Return of Professionals (New York: Bureau of Applied Social Research, 1973; issued jointly with the Agency for International Development, Washington).

6) Outflow of Trained Personnel from Developing to Developed Countries: Report by the Executive Director of the United Nations Institute for Training and Research (New York: Economic and Social Council, The United Nations, Fiftieth Session, Agenda Item 3, 9 February 1971, Document E/4948, in four languages).

7) Sheltered Employment of the Disabled: An International Survey (Geneva: International Labour Office, 1967; also Stockholm: National Labour Market Board, 1966).

8) Three Papers on the Integrated Bar (New York: Bureau of Applied Social Research and the New York State Bar Association, 1960). Some of this is reprinted in Vern Countryman (editor), The Lawyer in Modern Society (Boston: Little Brown and Company, 1966), pp. 348-355.

9) Health and Diplomacy (New York: Research Institute for the Study of Man, 1963).

10) A Harlem Almanac (New York: Bureau of Applied Social Research, 1964).

11) Social Science Data Archives in the United States 1967 (New York: Council of Social Science Data Archives, 1967).

d. Articles:

1) Migration:

a. "International Flows of Talent," in Roy Bryce-Laporte (editor), Sourcebook on The New Immigration (New Brunswick: Transaction Books, 1980), pp. 59-68.

b. "Results of the Work of the United Nations Institute for Training and Research," in The "Brain Drain" Problem: Outflow of Trained Personnel from Developing to Developed Countries--Report of the Secretary General (New York and Geneva: Economic and Social Council, The United Nations, Agenda Item 21, 9 June 1978, Document E/1978/92), pp. 16-23.

c. "Migration of Talent," International Encyclopedia of Higher Education (San Francisco: Jossey-Bass Inc., 1977), Volume 6, pp. 2731-2741.

d. "The Migration and Return of Professionals," International Migration Review, Volume 8, Summer 1974, pp. 227-244.

e. "The Brain Drain and UNITAR's Multinational Research Project on the Subject," Social Science Information, Volume XII, April 1973, pp. 123-138 (with Mehri Hekmati).

f. "The Brain Drain: What We Know and Need to Know," in A.B. Zahlan (editor), The Arab Brain Drain (London: Ithaca Press, 1981), pp. 231-244. Also published in Arabic.

2) Cross-national studies of organizations:

a. "Cross-National Comparisons of Factories," Journal of Comparative Administration, Volume 3, May 1971, pp. 83-118. Reprinted as "Der Industriebetrieb im interkulturellen Vergleich," Soziale Welt, Volume 23, 1972, pp. 293-318. German text reprinted in Lutz Zündorf (editor), Industrie-und Betriebssoziologie (Darmstadt: Wissenschaftliche Buchgesellschaft, 1979), pp. 303-345.

b. "Cross-National Comparisons of Organizations," International Studies of Management and Organization, Volume V, Spring 1975, pp. 68-90.

3) Cross-national studies of hospitals:

a. "Paying the Hospital: Foreign Lessons for the United States", Health Care Financing Review, Volume 4, Number 4 (Summer 1983), pp. 99-110.

b. "Krankenhauskosten im internationalen Vergleich", in Christian von Ferber et al. (editors), Kosten und Effizienz im Gesundheitswesen (München: R. Oldenbourg Verlag, 1985), pp. 221-247.

c. "For-Profit Hospitals--American and Foreign Comparisons", Health Care Management Review, Volume 9, Number 4 (Fall 1984), pp. 27-34.

d. "Juggling Multiple Payers", American Problems and Foreign Solutions, Inquiry, Volume XXI, Number 2 (Summer 1984), pp. 178-188.

e. "Hospital Rate Regulation -- American and Foreign Comparisons", Journal of Health Politics, Policy and Law, Volume 8, Number 4 (Winter 1984), pp. 702-731.

f. "American and Foreign Hospitals: Some Sociological Comparisons", in Eliot Freidson (editor), The Hospital in Modern Society (New York: The Free Press, 1963), pp. 37-72.

g. "The Problems of the Hospital Administrator: Some American and Foreign Comparisons", Hospital Administration, Volume 9, Summer 1964, pp. 6-22.

h. "Nursing Leadership and Policies: Some Cross-National Comparisons", in Fred Davis (editor), The Nursing Profession (New York: John Wiley and Sons, 1966), pp. 1-59.

i. "Paying the Hospital in the United States" in the Proceedings of the Workshop on Hospital Financing Systems (Copenhagen: World Health Organization Regional Office for Europe, 1986).

4) Cross-national studies of health insurance and health services:

a. "Health Politics: Lessons from Abroad", in Theodor J. Litman and Leonard S. Robins (editors), Health Politics, Policy and the Public Interest (New York: John Wiley and Sons, 1984), pp. 305-339.

b. "Lessons from Germany," Journal of Health Politics, Policy and Law, Volume 8, Number 2 (Summer 1983), pp. 352-364.

c. American Health Care Problems and Foreign Solutions," in International Perspective on Health Care: Learning from Other Nations, Hearings held on 1 May 1984 (Washington: U.S. Government Printing Office, Comm. Pub. No. 98-450, 1984), pp. 4-16.

d. "Long-Term Care: American Problems and Foreign Solutions," in Continuing Care: International Prototypes for America's Aged, Hearings held on 15 July 1985 (Washington: U.S. Government Printing Office, Comm. Pub. No. 99-523, 1-85), pp. 189-215.

e. "Canadian Health Care Problems and Foreign Solutions", in the Proceedings of the Colloquium on Health Care Issues (Ottawa: Economic Council of Canada, 1986).

f. "Payment Systems and Their Effects," in Linda Aiken and David Mechanic (editors), Applications of Social Science to Clinical Medicine and Health Policy (New Brunswick: Rutgers University Press, 1986), pp. 481-499.

g. "Paying Physicians for Geriatric Care: The Experience Abroad," in Proceedings of the Conference on Paying Physicians for Geriatric Care (Washington: National Center for Health Services Research, 1986).

h. "Services for the Aged: Foreign Lessons for the United States" in Aging: An International Perspective -- Proceedings of a Conference (New York: Brookdale Institute on Aging and Adult Human Development and the School of International and Public Affairs, Columbia University, 1982), pp. 60-63.

i. "Politics of Cost Control Abroad," Bulletin of the New York Academy of Medicine, Second Series, Volume 56, Number 1 (January-February 1980), pp. 107-114.

j. "What Can We Expect from National Health Insurance?" Columbia: The Magazine of Columbia University, Volume 4, Winter 1978, pp. 31-33. Also published as "National Health Insurance in Practice" in National Conference of State Legislatures, State Innovations in Health (Washington: Intergovernmental Health Policy Project, George Washington University, 1980), pp. 61-64.

k. "National Health Insurance in Federal Systems," The State Perspective on Health Policy: The Report of the Health Policy Consortium (Phase 3) (Washington: Center for Policy Research, National Governors' Association, 1979), pp. 137-150.

l. "Controlling Costs through Methods of Paying Doctors: Experiences from Abroad," in Stuart O. Schweitzer (editor), Policies for the Containment of Health Care Costs and Expenditures (Washington: U.S. Government Printing Office, 1978, DHEW Publication No. (NIH) 78-184, pp. 209-241.

m. "Improving Federalism in American Health Services: Some Ideas from Abroad," in Christa Altenstetter (editor), Changing National-Subnational Relations in Health: Opportunities and Constraints (Washington: U.S. Government Printing Office, 1978, DHEW Publication No. (NIH) 78-182), pp. 389-399.

n. "Socialized Medicine in Practice," The Public Interest, Spring 1966, pp. 90-106. Reprinted in: George S. Masannat (editor) Basic Issues in American Public Policy (Boston: Holbrook Press, 1970), pp. 271-289; Eliot Freidson and Judith Lorder (editors), Medical Men and Their Work (Chicago: Aldine-Atherton, 1972), pp. 65-81; and Ray H. Elling (editor), National Medical Care (New York: Atherton Press, 1970), pp. 38-59.

o. "Medical Care: Social Aspects," International Encyclopedia of the Social Sciences (New York: The Macmillan Company and the Free Press, 1968), Volume 10, pp. 93-100.

p. "From National Findings to Cross-National Generalizations," Transactions of the Fifth World Congress of Sociology, 1962 (Louvain: International Sociological Association, 1964), Volume IV, pp. 465-471.

q. "Medical Administration in Russia--Some Recent Impressions," The Lancet, 16 December 1961, pp. 1352-1354.

r. "International Survey of Sheltered Employment," International Rehabilitation Review, Volume 18, July 1967, pp. 17-18. Reprinted in Phoenix News, Volume 7, December 1967, pp. 7-8.

s. Contributing author to Mottram Torre (editor), Selection of Personnel for International Service (New York: World Federation for Mental Health, 1963).

5) Sociological analyses of the health professions in the United States:

a. "Doctors and Politics," The American Journal of Sociology, Volume LXVI, November 1960, pp. 230-245. Revised version published as "The Political Values and Behavior of Doctors," in Joseph R. Fiszman (editor), The American Political Arena (Boston: Little Brown and Company; First edition, 1962, pp. 487-499; Second edition, 1966, pp. 440-457). Condensed version published in Cahiers de Sociologie et de Démographie Médicales, Volume III, April-June 1963.

b. "Evaluation of Performance in Public Health Nursing," Nursing Research, Volume 10, Winter 1961, pp. 32-37 (With Frances McVey).

c. "Effects of Public Health Field Practice upon Career Preferences and Career Plans," Nursing Research, Volume 14, Winter 1965, pp. 61-65 (with Frances McVey).

d. "The Performance of Students in Public Health," Nursing Research, Volume 14, Spring 1965, pp. 138-142 (with Frances McVey and Molly Schirm).

e. "Internship Appointments of Medical Students," Administrative Science Quarterly, Volume 4, December 1959, pp. 337-356.

6) International technical assistance.

a. "Experts and Counterparts in Technical Assistance," in Krishna Kumar (editor), Bonds without Bondage: Explorations in Transcultural Cooperation (Honolulu: The University Press of Hawaii, 1979), pp. 207-225.

b. "Improving Communication in the Technical Cooperation Relationship," Focus: Technical Cooperation, 1975/3, pp. 10-14. A special section of the International Development Review, Volume XVII, 1975.

c. "Making Better Use of Technical Assistance Experts," Focus: Technical Cooperation, 1975/4, pp. 21-25.

7) Politics and Government:

a. "Television and Voting Turnout," The Public Opinion Quarterly, Volume 29, Spring 1965, pp. 73-86. Reprinted in Joyce Gelb and Marian Palley (editors), The Politics of Social Change (New York: Holt, Rinehart and Winston, Inc. 1971), pp. 209-222.

b. "Intention and Voting Turnout," The American Political Science Review, Volume LII, December 1958, pp. 1030-1040. Reprinted in Paul F. Lazarsfeld et al (editors), Continuities in the Language of Social Research (New York: The Free Press, 1972), pp. 367-375.

c. "The Family and Voting Turnout," The Public Opinion Quarterly, Volume 23, Winter 1959-1960, pp. 563-570.

d. "Job Mobility between Government and Other Social Structures," PROD (later called The American Behavioral Scientist), Volume III, November 1959, pp. 20-23.

e. "The Types and Uses of Political Theory," Social Research, Volume 22, Autumn 1955, pp. 275-296. Reprinted in James A. Gould and Vincent V. Thursby (editors), Contemporary Political Thought (New York: Holt, Rinehart and Winston, Inc., 1969), pp. 70-88; and in George S. Masannat and Thomas W. Madron (editors), The Political Arena (New York: Charles Scribner's Sons, 1969), pp. 44-56.

f. "The Semantics of the Cold War," The Public Opinion Quarterly, Volume 20, Winter 1956-1957, pp. 691-716. Reprinted in J. K. Zawodny (editor), Man and International Relations (San Francisco: Chandler Publishing Company, 1967), Volume I, pp. 675-688.

g. "Theories of Soviet Foreign Policy--A Classification of the Literature," World Affairs Quarterly, Volume 27, July 1956, pp. 128-152.

h. "Algie Martin Simons and Marxism in America," The Mississippi Valley Historical Review, Volume 41, December 1954, pp. 419-434.

i. "The Units of Political Action", The Southwestern Social Science Quarterly, Volume 35, June 1954, pp. 23-35.

j. "A.M. Simons: American Marxist," Institute of Social Studies Bulletin, Volume I, Summer 1952, pp. 66-67, 94.

8) Research methods:

a. "International Mail Surveys of Informants," Human Organization, Volume 25, Spring 1966, pp. 78-86.

b. "The Process of Cross-National Survey Research," in Alexander Szalai et al. (editors), Cross-National Comparative Survey Research: Theory and Practice (Oxford: Pergamon Press, 1977), pp. 403-436. Reprinted in part in Comparative Interdisciplinary Studies Section Bulletin, Volume 5, November 1975.

c. "Plans of the Council of Social Science Data Archives," Social Science Information, Volume 5, December 1966, pp. 71-96 (with Ralph Bisco).

d. "Note on the work of the Council of Social Science Data Archives 1965-1968," Social Science Information, Volume 8, April 1969, pp. 159-176.

e. Editor-in-Chief and author of much of the contents of the quarterly news magazine, Comparative Research, 1978-1982.

f. Reports for clients of the Bureau of Applied Social Research, including about six papers for the Western Reserve University School of Medicine during 1958.