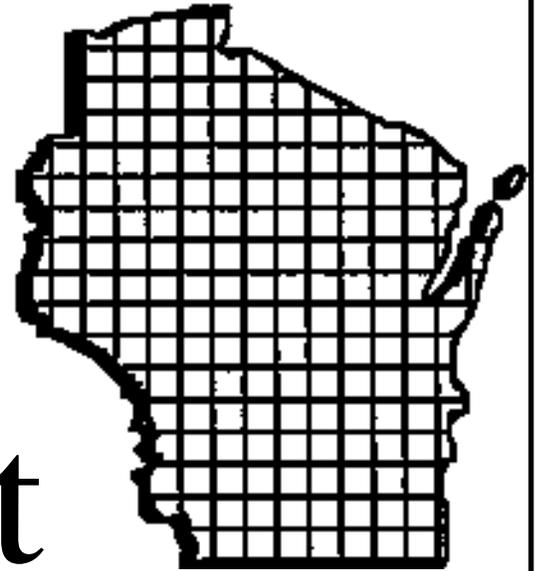


Wisconsin

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Research
Institute

Report



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**THE HISTORY OF
HEALTH CARE
COSTS AND
HEALTH
INSURANCE**

A Wisconsin Primer

REPORT FROM THE SENIOR FELLOW:

Every opinion poll shows Wisconsin citizens are worried about the cost of health care. It is affecting the security of every family and the bottom line of every business. We have come to expect soaring health care costs each year and we feel almost helpless to do anything about it. How did it get this way?

That is the question we asked Linda Gorman, Ph.D. to research for us. As the Director of the Health Care Policy Center for the Independence Institute, Dr. Gorman is well qualified to answer the question. Her report points out critical flaws in the American health care system that date back to the Great Depression.

It was during the Depression that hospitals banded together to offer prepaid coverage to citizens. Prepaid hospital coverage was a way for hospitals to avoid the financial failure that befell the banking industry. The approach worked so well that doctors followed suit a few years later and Blue Cross Blue Shield organizations were born. Little did anyone know that the seeds for runaway costs eighty years later had been planted.

Prepaid, employer-provided insurance quickly dominated the health care landscape. Subsequent action by the federal government in the 1950s to provide a tax deduction for health insurance premiums helped solidify the approach. To set the system in concrete, in the 1960s the federal government created Medicare and Medicaid, two programs patterned closely after the Blue Cross model.

While the resulting American health care model proved a clever way to ensure that the money would roll in from patients, employers, and government, it contained a flaw that is proving fatal. The flaw is that health care consumers have been removed from participating in decisions regarding their care. Our approach to health insurance ignores the important role consumers play in controlling costs and enhancing quality. Dr. Gorman found that people who pay for their own care cut utilization by 10% to 30% with no discernable effect on health. Saving even 10% of Wisconsin's 2002-2003 health care spending would have saved \$260 million.

Fortunately a movement has begun to put consumers in the central role where they belong. In a subsequent study Dr. Gorman will examine how consumer-driven health care can serve to control costs and improve the quality of our health care.

George Lightbourn

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THE HISTORY OF HEALTH CARE COSTS AND HEALTH INSURANCE

A Wisconsin Primer

LINDA GORMAN, PH.D.

	PAGE
EXECUTIVE SUMMARY	1
INTRODUCTION	3
LEGISLATING A MESS: GOVERNMENT INTERVENTION AND THE EARLY HISTORY OF THE HEALTH CARE PAYMENTS SYSTEM	3
HEALTH INSURANCE REPLACES SICKNESS PAYMENTS	6
THE MEDICARE AND MEDICAID ENTITLEMENT: UNINTENDED CONSEQUENCES STRUCTURED BY POLITICIANS FOR POLITICIANS	10
RAND HEALTH EXPERIMENT: EXPANDING OUT-OF- POCKET PAYMENTS REDUCES EXPENDITURES WITH NO MEASURABLE EFFECT ON AVERAGE HEALTH	11
SPENDING TAKES OFF; OUT-OF-POCKET COSTS DECLINE	12
SPENDING GROWTH IN OTHER INDUSTRIALIZED COUNTRIES OUTPACES THAT IN U.S.	14
HIGHER AMERICAN SPENDING PRODUCES BETTER HEALTH CARE	15
HEALTH POLICY EXPERTS EMBRACE CENTRALIZED CONTROL IN AN EFFORT TO CONTROL COSTS	18
THE SEARCH FOR QUALITY MEASURES TO REPLACE CONSUMERS	21
THE PROMISE OF CONSUMER-DIRECTED CARE	23
SUMMARY	26
NOTES	28

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EXECUTIVE SUMMARY

Locked into an eighty-year-old model that prescribes central planning for every aspect of the U.S. health system, America's system of delivering health care has lost sight of the important role that consumers play in controlling health system costs and quality. Real world experiments suggest that people who pay for their own care cut utilization by 10% to 30% with no discernable effect on health. Saving even 10% of Wisconsin's 2002-2003 health care spending would have saved \$260 million.

But how did this happen? How did the Wisconsin health care consumer become a passive cog in a very expensive machine? Interestingly, the answer has its roots in the Great Depression when health care consumers were divorced from decisions about spending on their health.

Hospitals, hit hard by the Great Depression, rushed to embrace plans for prepaid health care as a way to survive. In 1939 the American Hospital Association began allowing plans that met its standards to use the Blue Cross name and logo. State legislatures agreed not to treat Blue Cross plans as insurance, based on the rationale that they were owned by hospitals. This permitted Blue Cross plans to operate as non-profit corporations, escaping the 2% to 3% premiums generally charged private insurance companies, and exempted them from insurance company reserve requirements.

Worried that the hospitals would expand the Blue Cross concept into physician services, physicians began thinking about their own organization. By 1946 all of the prepaid physician services plans had affiliated and became known as Blue Shield.

Since the primary concern of the early Blue Cross and Blue Shield plans was to ensure that hospitals and physicians were paid, the plans covered all costs, and everyone in the same geographic area paid the same price. This encouraged patients and their doctors to use medical care without worrying about costs.

By 1945 Blue Cross had captured 59% of the health insurance market. The idea of prepaid health insurance was solidified on the American landscape in 1954, when the Internal Revenue Code codified the deductibility of health insurance payments. The employer deduction significantly reduced the cost of health insurance for consumers eligible for an employer-provided group plan.

The federal government cast the Blue Cross Blue Shield approach in regulatory concrete in 1965 when Congress passed the Medicare and Medicaid programs. Medicare copied the Blue Cross Blue Shield pay-as-you-go approach to health insurance and applied it to almost all Americans over 65. Ironically, at the time, relatively few people were expected to benefit, since for men born in 1950 life expectancy was only 66 years. For women it was 71.7 years. As life expectancy has grown, so too has spending on the two government programs.

Unable to impassively watch as health care spending spiraled upward, federal health care planners imposed an armada of regulations on the manner in which health care was provided to Medicare and Medicaid patients. The regulatory binge in U.S. health care since the 1970s has produced nearly 50 kinds of federal and state health services' regulations, which by 2002 was costing roughly \$340 billion, about 20% of total health spending of \$1,560 billion.

More promising recent reforms emphasize a return to consumer-directed health spending in which consumers who spend less on their health benefit directly. Health Savings Accounts made their debut in 2002. Early results from employers offering these and less consumer-friendly arrangements suggest that people spending their own money spend less, have fewer hospital admissions and emergency room visits, and are more meticulous in their use of prescription drugs. As Health Savings Account balances will likely build up rapidly for the majority of people who are in good health, they also provide hope for the fiscal Titanic that is Medicare.

In 2002, the State of Colorado turned conventional wisdom on its head with a pilot program that allowed about 146 severely disabled Medicaid patients to use state funds to hire and fire their own home health aides. Average monthly spending dropped by 21%. Care was better and patients split the savings 50/50 with the state, allowing them to buy needed equipment like voice-activated telephones.

Two clear choices face those who would shape future U.S. health care policy. Continuing to follow old habits of layered regulation, third party payment, and increasing government control will continue the current cost spiral and the recent deterioration in patient care. To protect a bankrupt Medicare program, government involvement will be extended into every nook and cranny of U.S. medical care. The regulatory overload will end private medicine and encourage those who can afford it to purchase their health care abroad.

The other choice is to deregulate, returning insurance to its traditional role as protection against bankruptcy and promoting savings to pay for the higher health expenses that generally accompany old age. Let consumers spend their own money on health care, free of interference from professors with statistical studies and bureaucrats with specific notions of how people ought to behave. This is the choice that has the potential to stop the cost spiral, lower costs, and provide better health care for all Americans.

INTRODUCTION

For the last 100 years, a health care regulatory project enthusiastically endorsed by generations of health policy experts has been encrusting U.S. health care with layer upon layer of increasingly intrusive regulation. Though each regulation may be innocuous in its own right, taken together they have had the unfortunate effect of divorcing patients from spending on their health, creating explosive growth in Wisconsin's Medicaid budget, and making Wisconsin's market for hospital services one of the least competitive in the United States.

In hindsight, the regulatory program had had three major achievements. It has excluded consumers from health care decisions, consistently moving the power to make decisions about the shape and substance of health care and health care financing from individuals to central planners. It has increased the number of health services that individuals could receive and have paid for by other people's money. Finally, it has perpetuated and refined a payment system that was originally intended to protect hospital incomes during the Great Depression. With the addition of price controls, that system now threatens to afflict Americans with the same health services problems that plague Canada, Britain, New Zealand, and the European systems.

With its focus on cost and third party payment, the regulatory program has also managed to shift the public debate. The historical focus on caring for an individual patient has been subsumed in discussions of pricing, cost control, and the merits of using a variety of delivery systems for expanding the third party payments system to an ever-increasing fraction of the population, legal or not. The collateral damage has been high. People have lost sight of the important role that involved consumers spending their own money play in controlling system costs and quality. They also have scant appreciation for the fact that the private health care delivery system that evolved in the United States was unique in its ability to produce superior health care at lower cost for all income levels.

The regulations removing consumers from direct decisions about health care expenditures have contributed a great deal to Wisconsin's exploding health care costs. The good news is that judicious deregulation has the potential to put consumers back in charge. Doing this requires a clear understanding how injudicious regulation has short-circuited normal market mechanisms for controlling expenditure, and an appreciation for the enormous benefits to be gained from meaningful consumer involvement. This paper examines why the reforms of the regulatory project backfired, why many current proposals have the potential to do the same, and why the new initiatives in consumer-directed care have such promise.

LEGISLATING A MESS:

GOVERNMENT INTERVENTION AND THE EARLY HISTORY OF THE HEALTH CARE PAYMENTS SYSTEM

Those alarmed at current health care costs and nostalgic for those of times gone by generally fail to appreciate that policy makers in the 1920s considered health care too costly and were concerned that the majority of American households lacked access to it.

As late as 1910, "the cost of health care treatment was considered a minor problem compared to the loss of wages due to sickness for most workers."¹ In the early 1900s, patients either lived or died. Care was largely limited to preventing disease by keeping clean, recommending good diets, providing good nursing, performing basic surgery, and praying for a rapid recovery.

Although Semmelweis had demonstrated the importance of hand washing as early as 1847, and Lister had shown that properly used antiseptics could cut post-operative mortality for amputations to 15% from 46% by 1867, medical progress of direct benefit to patients proceeded at a measured pace at the end of the 1800s.² With the exception of smallpox, vaccines against diseases caused by viruses were not developed until after World War II.

The most dramatic medical advance in the 1920s occurred when Banting, Best, and Macleod converted diabetes from a death sentence to a treatable condition by discovering the active ingredient in insulin at the University of Toronto in 1921.³ Unfortunately, they were unable to produce large quantities of it. In 1922, scientists at Eli Lilly formed "the first long-term, large-scale case of biomedical collaborative research between a North American university and a pharmaceutical firm," in an effort to produce insulin in reliable quantities.⁴ Lilly finally succeeded in 1923 after its chief chemist, George Walden, developed a new method of isoelectric precipitation in late 1922.⁵

The Health Care Cost Spiral of the 1920s

For most of the 1800s, hospitals had been a place where the chronically ill and indigent received charitable care because they had no family capable of shouldering the burden. Those who could afford it received care at home. But as the importance of asepsis began to be appreciated, surgical and acute care patients were more likely to be treated in hospitals designed to facilitate antiseptic conditions. Hospitals began charging for the use of their facilities.

During the transition, medical bills began absorbing significant amounts of family income. Hospital costs rose from 7.6% of total family medical bills in 1918, to 13% in 1929.⁶ According to the *Historical Statistics of the United States*, average annual earnings in all industries and occupations in 1926 were \$1,473 when farm labor was excluded. Thomasson reports that surveys of medical care expenditures from 1929 show that U.S. urban families, with above-average annual incomes of \$2,000 to \$3,000 that had no expenses for hospitalization, spent an average of \$67 a year, 2% to 3% of income, on medical care. With hospitalization, the average was \$261, 8% to 13% of annual income.⁷

According to Ross, by 1934 “hospital bills and physicians’ bills for inpatient services had grown further to 40% of total family medical cost. These rising costs alarmed leaders in medicine, labor, and government. The discussion of health insurance was reborn.”⁸

Comparing the health care costs of modern families with those borne by people in the early 1900s helps put the modern health care cost discussion in perspective. Table 1 shows the percentage of family income spent on health care for various periods since 1917. As a fraction of total actual expenditures, health care costs grew until 1960 and then declined. By the late 1980s they were a lower fraction of a family budget than they were in 1917-1919. These figures do not include expenditures for employer-provided health insurance.

Data from the 2002 Consumer Expenditure Survey suggest that out-of-pocket spending is still below levels prevailing in the middle of the century. In 2002, married husband and wife families in the United States earned an average of \$72,720 before taxes. Members of this group are generally healthy and covered by group insurance purchased

from their employers with pretax payments. As a group, they spent an annual average of \$2,676 on health care, about 4% of income before taxes.⁹

These spending data are in accord with data from the Medical Expenditure Panel Survey. Average out-of-pocket spending for modern Americans, the amount roughly equivalent to expenses for the 1929 family, averaged \$1,308 per family. This ranges from 3.6% of family income at the bottom of the middle income category

TABLE 1 SHARES OF FAMILY CONSUMPTION (FOR AN URBAN FAMILY WITH ONE WAGE EARNER) USING ACTUAL EXPENDITURES, IN PERCENT.

Component	1917-19	1950	1960-61	1972-73	1986-87
Food	41.1	32.5	26.0	22.6	19.4
Housing	26.8	26.0	29.2	29.3	33.7
Transportation	3.1	13.8	15.1	24.1	25.7
Clothing	17.6	11.6	10.3	8.4	5.2
Health care	4.7	5.1	6.6	4.7	4.0
Other	6.7	11.0	12.8	10.9	12.0

SOURCE: Eva Jacobs and Stephanie Shipp, “How family spending has changed in the U.S.,” *Monthly Labor Review*, March 1990, pp. 20-27 cited in David S. Johnson, John M. Rogers and Lucilla Tan. May 2001. “A Century of Family Budgets in the United States,” *Monthly Labor Review*, online edition <http://www.bls.gov/opub/mlr/2001/05/art3full.pdf> (accessed November 13, 2005), p.32.

to less than 2% of family income at the top, less than half of the amount paid for a comparable family in 1929.¹⁰

Early Expert Recommendations to Control Costs

Then as now, rising health care costs were the subject of active public debate. Proposals to solve the problem abounded. It is striking how little the reform recommendations of physicians groups, academics, and government bureaucrats have changed between the early 1900s and the early 2000s. Despite revolutions in economics that have led to a far deeper understanding of the essential role that prices and profit play in delivering consumer value, reducing costs, and encouraging innovation, and to an unveiling of the potential for self-interested behavior on the part of

non-profit groups like government, health policy experts still recommend the same non-market reforms that were popular at the beginning of the last century.

Following the lead of the European countries that had created tax-supported, government-run health care schemes, the Progressive party included national health insurance for the United States in its party platform in 1912. World War I and public opposition defeated the measure at the national level. By 1915, the drive for national insurance had shifted to the states. The American Association for Labor Legislation drafted a model state medical care insurance bill, and introduced it in sixteen states. Unlike modern proposals, the model insurance created by the Association was a blend of health insurance and disability. It would have covered both health care costs and two-thirds of lost wages for 26 weeks.¹¹

At the 1926 American Medical Association (AMA) national convention, “15 frustrated delegates decided to investigate, and attempt to solve, the organizational problems leading to the rising costs of medical care.”¹² Concern was high. In 1927, “the inability of the people to pay the cost of modern scientific medicine” was the first item on the agenda at the AMA convention. A committee of the AMA produced the first estimate of national health care spending, about 4% of national income or \$3.66 billion in 1929.¹³

The committee’s final recommendations reflect the economic zeitgeist of the times, an era suffused with progressive reformers, socialists, trade unionists, and admirers of Bismarkian social insurance schemes, all unified in their devotion to decidedly murky forms of egalitarian social justice, and their conviction that central planning could cure most human ills. Scant attention was paid to the benefits of competition or to the harm that would follow when self-interested government agencies and non-profit organizations gained control of the legislative machinery dictating the practice and delivery of health care.

In the committee’s final report, the majority opinion concluded that “even among the highest income group, insufficient care is the rule, and [that] the basic solution to this problem was to increase the proportion of national resources going to medicine.”¹⁴ Although it opposed compulsory health insurance, the majority opinion came down on the side of prescriptions that were decidedly group-oriented. The contemporary *New York Times* headline informed readers that “Socialized Medicine Is Urged in Survey.”¹⁵

Then as now, comprehensive medical services were to be reorganized for delivery “largely by organized groups of practitioners, organized preferably around hospitals, encouraging high standards, and preserving personal relations.” Scant consideration was given to the nitty-gritty details of how such a scheme would actually operate in practice.

Both the American Medical Association and Dr. William J. Mayo, one of the founders of the Mayo Clinic, were members of the minority on the committee. Dr. Mayo’s disagreement is especially interesting. By 1929, a number of group practices, including the Mayo Clinic, had achieved national reputations. It was one of the largest group practices in the nation. Employing nearly 400 doctors and dentists and a thousand other clinicians, it was just the sort of organized group practice that the members of the majority had in mind when they recommended that care be delivered via organized groups affiliated with hospitals. Other large group practices that presumably fit the majority model at the time were the Cleveland Clinic, founded in 1891; the Marshfield Clinic, founded in 1916; the Menninger Clinic, founded in Topeka, Kansas in 1919; and the Lahey Clinic, founded in Boston in 1925.

As has so often been the case in the past two decades, the committee recommended radical reforms in service delivery based on what were said to be good results achieved by a relatively small number of current practitioners. At the time, group practices were the exception. According to Stewart, “various national surveys identified one hundred fifty to three hundred group practices (depending on definition), with an average group size of six to eleven physicians.”¹⁶ Assuming eleven physicians per practice, this means that approximately 3,300 of the nation’s roughly 154,000 physicians were in practices of the type the committee thought should become the main delivery vehicle for medical care in the United States.

At the time the committee’s recommendations were finalized, the American Medical Association had already spent almost two decades methodically raising educational requirements for physicians. It had succeeded in tightening licensing requirements as a part of its efforts to raise professional standards. Those activities almost certainly contributed to the health care cost spiral in the early 1900s. Then as now, the ironic result was that by requiring credentials that may or may not have had any consumer benefit, a committee convened to reduce costs almost certainly ended up increasing them.

Centralized Solutions Ignore Consumers, Empower Producers.

After its founding in 1847, the American Medical Association had a number of unsuccessful programs to raise payments to orthodox physicians. Its successful effort to raise member income began at the turn of the century and included both a membership drive and a push for legislatively-enacted professional standards. Members were promised smoother access to hospital privileges, protection from malpractice litigation, and the benefits of organized county medical societies. The new formula worked. Between 1900 and 1925, membership increased from less than 10% of U.S. medical practitioners to almost 50%.

Bolstered by its new grassroots support, the AMA campaigned to encourage state legislatures to set standards for medical education and physician licensing. As is always the case when a trade association seeks to limit entry into its business or profession, the benefits of higher professional standards come with increased costs. As consumers may neither want nor need higher-quality services, there is no guarantee that requiring them will improve consumer welfare.

The standards effort had began in earnest in 1906 when the AMA had its Council on Medical Education inspect the nation's medical schools. It determined that more than half of them were deficient. To add weight to the AMA findings, the respected Carnegie Foundation commissioned Abraham Flexner to evaluate American medical schools. Enormously influential, the Flexner report helped convince legislators in a number of states that only graduates of Class A medical schools were fit to be licensed as medical doctors. It also succeeded in convincing state governments that the certification of medical schools should be delegated to the AMA.

With the AMA in charge of certifying both medical schools and the standards for licensing physicians, the number of medical schools fell from 162 in 1906 to 85 in 1919. The schools that survived were generally associated with hospitals and universities.

As training requirements became increasingly arduous and expensive, the number of physicians per capita in the United States declined from 157 per 100,000 in 1900 to 125 per 100,000 in 1930.¹⁷ The AMA was successful in controlling the number of U.S. training slots for physicians for the rest of the century.

HEALTH INSURANCE REPLACES SICKNESS PAYMENTS

While the health care community and academics searched for a single insurance plan for delivering health care, the absence of regulation left individual Americans free to solve the problem on their own. They proceeded to do so, aided in the effort by a number of medical entrepreneurs.

In spite of the price increases, most people still paid for medical care out of their own pockets. Estimated health expenditures in 1929 were \$3,649 million. Of that, consumers paid \$2,937 million, public sources paid \$495 million, and philanthropy paid \$217 million.

Employer plans covered only a tiny minority of people. Most sickness insurance was provided by mutual benefit associations unrelated to work — fraternal societies like the Loyal Order of Moose, the Knights and Ladies of Security, the Ladies of the Maccabees, and the Société Française de Bienfaisance Mutuelle, which built San Francisco's French Hospital in 1852. According to Stewart, there were thousands of fraternal societies operating in New York's Lower East Side at the beginning of the 1900s. Existing for the benefit of their members and offering benefits that were not contingent on employment, many of the societies "employed or contracted with physicians to care for dues-paying members for as little as \$1 to \$2 per year per member. In some eastern and southern cities, a third to a half of some ethnic groups depended on these organizations for medical care. In New Orleans 88% of the entire population was said to be covered by some form of prepaid 'contract medicine,' also known as 'lodge medicine' by 1888."¹⁸

Historian David Beito estimates that in 1910 at least one-third of adult males belonged to fraternal societies that provided nearly every service of the modern welfare state "including orphanages, hospitals, job exchanges, homes for the elderly, and scholarship programs."¹⁹ Fraternal societies had a number of competitors including "commercial-group plans, government workmen's compensation programs, trade unions and industrial unions, company-sponsored mutual benefit societies, and other fraternal orders that provided life insurance or non-stipulated (discretionary) relief."²⁰

The fact is that the fraternal societies knew their members gave them an advantage in issuing disability and sickness insurance. Lodges had home visiting committees that helped uncover false claims and one or two week waiting periods requiring members applying for aid to shoulder some of the financial load. Unlike many of the public proposals, the societies also had behavioral requirements that made life less attractive while receiving payments. Emery reports that fraternal groups could require that “members receiving benefits could not drink or gamble and in some cases were not allowed to be away from their residence after dark.”

The voluntary payment arrangements epitomized by the fraternal societies came under attack at the turn of the century. By 1910 the medical societies developed as a part of the American Medical Association’s effort to organize physicians had begun pressuring licensing authorities to deny licenses to doctors who accepted lodge contracts. Hospitals were also pressured to “close their doors to fraternal members who used ‘lodge doctors.’”

A broader form of prepaid employer-provided hospital care appeared at the end of the 1920s when a group of Dallas teachers arranged for Baylor hospital to provide 21 days of hospitalization to its members in return for a \$6.00 annual payment. As described by Melissa Thomasson of Miami University, “the Baylor insurance was developed as a way to ensure that people paid their bills. One official connected with the plan compared hospital bills to cosmetics, noting that the nation’s cosmetic bill was actually more than the nation’s hospital bill, but that ‘We spend a dollar or so at a time for cosmetics and do not notice the high cost. The ribbon counter clerk can pay 50¢, 75¢, or \$1 a month, yet . . . it would take about twenty years to set aside a large hospital bill.’”²¹

By attaching sickness insurance to the workplace, the Baylor plan automatically selected for healthier people. Its members had to be well enough to work. In 1929, Donald Ross and H. Clifford Loos contracted with the Los Angeles Department of Water and Power to provide prepaid comprehensive health care to its employees and their dependents. By the mid-1930s other employee associations had joined, and the plan covered 37,000 people.

States Protect Hospitals With Laws Favoring Blue Cross

Hospitals hit hard by the Great Depression wanted to make sure they were paid and rushed to embrace plans for prepaid health care. As the banks failed, Americans tightened their belts. According to Paul Starr, “in just one year after the crash [of 1929], average hospital receipts per person fell from \$236.12 to \$59.26.”²² Though public hospitals that accepted charity care filled 89% of their beds, by 1931 private hospitals were reduced to 62% occupancy.²³ Hospitals had facilities to support and staff to pay whether patients used their facilities or not. They knew that prepaid health plans could benefit them by producing a steady cash flow. The American Hospital Association (AHA), began to market prepaid hospitalization plans as something that also benefited patients by “relieving [them] . . . from financial embarrassment, and even from disaster in the emergency of sickness, those who are in receipt of limited incomes.”²⁴

Because prepaid plans run by single hospitals generated competition among hospitals, “community hospitals began to organize with each other to offer network hospital coverage reducing inter-hospital competition. These plans eventually combined under the auspices of the American Hospital Association, which in 1939 adopted the Blue Cross name and logo as the national symbol for plans that met its requirements.”²⁵ Member hospitals began offering discounts to Blue Cross plans in the 1930s.

As had been the case with physicians, state legislatures were more than willing to let the American Hospital Association set the terms under which hospital health insurance would operate. It was perceived that Blue Cross plans were not insurance because they were owned by hospitals; states exempted them from normal insurance company requirements. They were allowed to operate as non-profit corporations, escape the taxes of 2% to 3% of premiums that most states levied from private insurance companies, and exempted from reserve requirements designed to insure the solvency of regular insurance companies.

Pay-As-You-Go Insurance Puts Non-Profit Bureaucracies in Control

As Blue Cross plans and the idea of national health insurance became more popular in the mid-1930s, physicians began worrying that hospitals would expand the prepaid plan concept into physician services. In 1934 the American Medical Association adopted ten principles aimed at answering proponents of national insurance and preventing hospital service plans from underwriting physicians’ services. Legislation exempting prepaid physician services plans

from insurance regulations and establishing their non-profit status was passed, along with requirements that ensured physician representation on plans providing prepaid physician services. In 1939, the first prepaid physician services plan began operation in California. The American Medical Association encouraged state and local medical societies around the country to form similar plans, and in 1946 they affiliated and became known as Blue Shield.²⁶

The special legislation exempting the Blues from normal insurance company requirements in exchange for a non-profit status channeled the various experiments in American health insurance towards a pay-as-you-go cost-plus system run by non-profit bureaucrats. It is likely that the special legislative treatment given the Blues in their early days helped fuel their explosive growth. According to economist John Goodman, at the beginning of the 1990s “net revenues (premiums minus benefit payments) on group policies [were] usually less than 5% of total premiums, [therefore] a 2% to 3% premium tax is equal to about 50% to 60% of net revenues.”²⁷ And because Blue Cross combined hospitals into a network that prevented competition from stand-alone facilities, its structure made it almost impossible for any other kind of insurer to offer benefits that differed markedly from the Blue Cross Standard.

In effect, ad hoc legislation designed to protect hospitals resulted in a system that limited product innovation. Potential competitors to the Blues would have to surmount almost impossible tax advantages. Then as now, patients who were not members of a hospital-favored insurance plan would have to pay more for services and since all services were paid for by a third party, patient incentives to watch over costs were effectively blunted.

The intellectual climate of the 1920s and 1930s had celebrated the superiority of socialist ideas of economic organization. Unfortunately, the notion that more tax money and enhanced centralized control can reduce health care costs has proven to be extraordinarily durable. The following decades were to see the implementation of many of the solutions proposed by the Committee on the Costs of Medical Care. Preserved in the regulatory amber that accreted steadily in the 1930s, 1940s, 1950s, and 1960s, the flaws inherent in the 1930s solutions plague U.S. health care consumers to this day.

In 1939, just 6% of the U.S. population had any kind of private health insurance for hospitalization. By 1941, the number had increased to 12.4%. Fifty-one percent of those covered had a policy from Blue Cross Blue Shield, 33% had group or individual policies from insurance companies, and almost 14% had insurance provided by community groups, individual practice plans, unions, private group clinics, or similar arrangements. The number of insured had risen to 23% by 1945, 59% of whom were covered by Blue Cross Blue Shield. As the U.S. financial system developed, more private insurers entered the market and the Blue Cross Blue Shield percentage drifted slowly downwards, falling to 49% by 1950, and 44% in 1960. By 1970, an estimated 86% of the population had some sort of hospitalization coverage, 46% of which was provided by Blue Cross Blue Shield.²⁸ This suggests that, then as now, roughly 14% of the population was uninsured.

The Pay-As-You-Go System Supplants Conventional Insurance

There were large differences between Blue Cross operations and the operation of conventional insurance companies, differences that were to have profound effects on the cost of health care in the decades that followed. Normal insurance contracts are a bilateral arrangement between an insured and his insurance company. A homeowner who suffers a loss because his house burns down works with a claims adjuster from his insurance company to determine the amount he is owed by the company. The company performs on its contract by paying him an agreed-upon amount. The owner then goes out and hires the people needed to rebuild his home. In order to ensure that it is able to meet its contractual obligations to pay for unexpected losses, a conventional insurance company does two things: it charges the homeowner a premium based on the likelihood that he will incur a loss, and it maintains assets and reserves sufficient to pay for expected losses.

Though a homeowner rebuilding a house may incur costs for several years, his insurance company need not be involved after it pays him a lump sum at the time of his loss. His ability to pay for the services he needs is not contingent on continuing to pay premiums to his insurer while he rebuilds. The lump sum payment also gives the homeowner a large incentive to search for contractors who offer good value.

Under the pay-as-you-go system created by the Blues, insured members receive services as they are needed, but the company reimburses those providing the service, rather than those who either pay for the policy or receive the health care. No reserves are created from past premium income to pay losses. Next year's premiums are roughly the expected total costs of services demanded by members divided by the total number of members. And if a member

incurs a loss that will require a stream of future payments, an insurer is liable for continued payments only if an insured both continues to be covered by his employer and pays his premiums.

With a pay-as-you-go system for homeowner's insurance, each separate contractor would submit its bill to the insurer as the house was being rebuilt, and all insured homeowners would have their premiums increased to bear the additional costs. The costs would be whatever the insured and his contractors determined they should be, limited only by the maximum on his policy. If the homeowner becomes unemployed, changes employers, or stops paying his premium before his new house is finished, his insurer would stop paying for the rebuilding. John Goodman of the National Center for Policy Analysis points out that if life insurance operated on a pay-as-you-go basis, elderly widows expecting to receive monthly annuities from their husband's life insurance companies would have to continue paying monthly premiums to the life insurance company that, in time, could increase to exceed the value of their monthly annuity checks.²⁹

To make matters worse, because the primary concern of the early Blue Cross and Blue Shield plans was to make sure their members got paid, they stipulated that the plans cover all costs, even those for routine, easily affordable, services. Checkups and diagnostic procedures were covered, and people using plan benefits owed neither deductibles nor copays. Free of any direct financial responsibility, doctors and patients could command whatever medical services they wanted, and expect that payment would be made mostly with other people's money. And because the Blues' enabling legislation generally required community rating, early plans charged everyone in a given geographic group the same premium. The pattern was set for decades to come; people who used little medical care paid the same amount as those who used a lot.

By paying the charges of whatever hospital a doctor or patient picked, the Blue Cross reimbursement system also insulated hospital costs from any sort of competitive price system. As late as 1976, 50% of Blue Cross plans were reimbursing hospitals on a cost-plus basis.³⁰

The most common method was the per diem formula. Blue Cross simply divided a hospital's stated total costs by total patient days and then multiplied that amount by the fraction of total patient days accounted for by Blue Cross patients. The second formula, known as the Department Method, calculated the Blue Cross payment by multiplying each hospital department's cost by the fraction of total patients who were covered by Blue Cross and used the department. The third method, the Combination Method, arrived at the Blue Cross payment by calculating the per diem cost of routine services, multiplying it by the percent of patient days accounted for by Blue Cross patients and then adding that to the Blue Cross percentage of the total cost of ancillary services.

The three reimbursement methods used by the Blues did not create normal business incentives. They assumed that all hospital costs should be paid whether or not they were generated by an inefficient organization. For the non-profit Blues, a reduction in costs reduced the amount of revenue collected.

The reimbursement formulas also allowed hospital managements to manipulate prices so that payments from the privately insured could be used to subsidize the care given to other patients. By 1980, U.S. hospitals had no incentive to minimize their costs, figure out what hospital care really cost, control capacity expansions, specialize in services in which they were the low cost producer, or minimize patient stays. They also had no way to gauge how much value patients put on different aspects of their services.

Congress Penalizes Individuals, Subsidizes Employer-Provided Group Health Insurance

The regulatory changes that propelled the rapid expansion of employer-provided health insurance during and after World War II helped fuel the hospital cost spiral by completely removing consumers from any contact with health care costs. After Blue Cross showed the way, commercial insurers quickly realized that insuring employees through their employer was a good business and an effective way to lower risk. Companies also learned that experience rating, the practice of setting business premiums by looking at a few years of a group's past claims experience, was an adequate predictor of next year's costs.

Employer-provided insurance might have coexisted with policies offered by other groups had Congress, in the 1942 Stabilization Act, not chosen to give preferential tax treatment to employer-provided health insurance policies. The Stabilization Act imposed price controls on employers by limiting employee wage increases. Price controls always create problems, so at the request of employers it contained a loophole allowing employers to compete for scarce workers by offering health insurance to employees as a pre-tax fringe benefit.

In 1943, an administrative tax ruling stated that employers' payments to commercial insurance companies for group medical and hospitalization premiums on behalf of their employees were not taxable as employee wages. Thomasson stresses that the 1943 ruling was a limited one, and that it was not until 1954, when the new Internal Revenue Code was issued, that the deductibility of health insurance payments was clarified and made widely applicable. Its effects were far reaching—it reduced the cost of health insurance, and by making group insurance widely available, may have accounted for “up to 41% of the rise in the predicted probability of having insurance.”³¹

In a world in which American corporations faced little competition for their products thanks to a war that had reduced their main competitors' factories to rubble, rich tax-free benefits packages that covered even the most trivial medical expense became the norm. Vision insurance was added in 1957. It was followed by insurance for dental care in 1959. In 1951, 100,000 employees and their dependents were covered by major medical plans. By the end of 1960, major medical coverage had been extended to 32 million people. By the end of 1986, the number had reached 156 million.³²

THE MEDICARE AND MEDICAID ENTITLEMENT: UNINTENDED CONSEQUENCES STRUCTURED BY POLITICIANS FOR POLITICIANS

The Blue Cross Blue Shield approach to health insurance was cast into regulatory concrete when the Democrats won a majority in Congress in 1964 and immediately passed the Medicare and Medicaid programs in 1965. Medicare copied the Blue Cross Blue Shield pay-as-you-go approach to health insurance and applied it to almost all Americans over 65. Relatively few people were expected to benefit since men born in 1950 had a life expectancy of 66 years and women 71.7 years.³³ Medicare Part A covered hospital services, promising to pay usual and customary rates. Medicare Part B provided subsidized reimbursement for physician services at usual, customary, and reasonable rates.

Developed in closed sessions of the Ways and Means Committee without any of the public hearings that would have stimulated an informed public debate, the final Medicare bill was a poorly understood grab bag of special interest legislation 300 pages long.³⁴ Many of the federal and state health reforms that followed were developed in similarly sterilized forums designed to eliminate debate and grease the skids to ideologically-motivated, ill-tested, initiatives.

Most privately-designed commercial health insurance plans make people pay for smaller expenses up to some out-of-pocket limit, usually a few thousand dollars. After that, all expenses in a year are paid for up to the policy limit of \$1 million to \$3 million because people typically buy health insurance to pay for losses that they cannot.

Politically-designed health systems like Medicare answer to politicians, not customers. They typically concentrate on making large numbers of voters grateful by providing small benefits to a large number of people. Small numbers of extremely unhappy people make little difference. They have only one vote, and if they are in poor health they will soon be dead anyway.

As the Medicare program has developed, it has become apparent that it protects against relatively small losses and provides no protection at all for the relatively small number of people who incur large ones by spending more than 150 days in the hospital. This is a particular problem for the elderly because unlike virtually every reputable private health insurance policy, Medicare has no cap on the maximum amount its beneficiaries can be liable for each year. Medicare copayments automatically increase with health care costs, and individual liability can be substantial. They are quoted as 20% of the Medicare-approved amount for each service rather than as a fixed dollar amount. In 1997, 39,840 American citizens enrolled in Medicare had health care liabilities averaging \$22,124 per person. If they lacked supplemental insurance, they were responsible for all charges.

The other problem with Medicare is that, unlike private insurance policies, it is not a contract. Congress can change benefits at will. Enrollment in Part A is virtually automatic at age 65. American citizens cannot reject coverage without forgoing Social Security benefits, a condition that most people cannot afford.³⁵

Though people who equate health insurance with access to health care often attribute the decline in elderly mortality to the universal health entitlement created by Medicare, economists Amy Finkelstein and Robin McKnight found that Medicare had no effect on mortality in the elderly in the decade following its founding.³⁶ Mortality declines for 55 to 64-year-olds began several years before Medicare, suggesting that the decline for those aged 65 to 74, that began slightly after Medicare's inception, was not a result of the program itself.

Medicare did substantially reduce “the elderly's exposure to out of pocket [*sic*] medical expenditure risk” by forcing current taxpayers to pay for the care of retirees. Medicare participants in the top quartile of the out-of-pocket

et spending medical expenditure distribution spent almost 50% less, a reduction in average spending of about \$1,200 per person.³⁷ In short, Medicare shifted responsibility for medical care payments from the elderly to younger people still in the labor force. In doing this, Medicare simultaneously reduced the incentive to save for old age and degraded the ability of younger workers to do so.

Medicaid, the federal means-tested program to provide a rich menu of medical services to the poor, promised that the federal government would pay half of the costs of various benefits for those who qualified. Participating states were required to pay the other half, and to offer a minimum set of benefits to all comers. Other benefits were made optional, allowing the states to tailor their programs. Like Medicare, Medicaid paid providers for each individual service. Because the federal government paid half of all charges it encouraged state politicians to replace the state programs that had previously assisted the ill and destitute. Medicaid also removed virtually all financial responsibility from consumers. It now provides first dollar coverage for everything from transportation to and from the doctor, to school counseling for teenagers, to attendant care for the disabled.

Medicaid and Medicare revolutionized the way in which citizens of the United States thought about health care, changing it from something that people had to save for to an entitlement. Rather than encourage people to pay for their health care with their own money, Medicare and Medicaid institutionalized the notion that people could buy health care and pay for it with other people's money. As economist Burton Weisbrod noted, although the spread of insurance and public entitlement plans might have created an incentive for "patients and their physicians to utilize more health care resources," thus increasing aggregate health care expenditures to a level above what they would otherwise have been, it "does not follow that insurance would cause expenditures on health care to *grow* more rapidly."³⁸ Unless, of course, the number of people included under insurance and public entitlement plans continued to grow as well.

RAND HEALTH EXPERIMENT: EXPANDING OUT-OF-POCKET PAYMENTS REDUCES EXPENDITURES WITH NO MEASURABLE EFFECT ON AVERAGE HEALTH

Because the spread of insurance and public entitlement plans coincided with rapidly growing health care expenditures, the question of how cost-sharing affected medical expenses was an important part of the Medicare and Medicaid debates in the 1960s and 1970s. As health economist Joseph P. Newhouse explained, "cost-sharing appealed to many conservatives, who believed that patients sought (or physicians delivered) much 'unnecessary' medical care when care was free. But many liberals saw cost-sharing as a barrier, especially for the poor, to receiving 'necessary' care."³⁹ In the final legislation, Medicaid cost-sharing requirements were nonexistent and it was clear that the conservatives had lost the debate. In 2002, copayments for a large number of Wisconsin Medicaid services ranged from \$0.50 to \$3.00.⁴⁰

In order to settle the questions about the effect of cost-sharing, the federal government funded a major experiment on the effects of self-pay requirements on health care utilization. One of the largest and most carefully constructed social experiments ever conducted, the RAND Health Insurance Experiment studied the health and health expenditures of approximately 2,000 non-elderly families from six areas of the United States. Participants were followed for three to five years between 1974 and 1982.

Participating families were assigned either to a prepaid group practice or one of 14 fee-for-service insurance plans. The fee-for-service plans varied only in the fraction of charges billed to the participant and the maximum dollar expenditure cap. There were four coinsurance percentages: 0 (free care), 25%, 50%, and 95%. The coinsurance rate referred to the fraction of billed charges paid by the insured. There were also three levels of maximum dollar expenditures, caps on the amount that any family was expected to pay during each 12 month accounting period. The maximum dollar expenditures were 5%, 10%, or 15% of family income or \$1,000 whichever was less. As a result, the highest maximum dollar expenditure was roughly equivalent to \$3,000 in today's dollars.

The results of the RAND experiment were stunning. The most important result was that per capita expenses on the free plan were 45% higher than those for the 95% cost-sharing plan. Savings primarily came from a reduction in the number of contacts rather than in the intensity of services. For average adults, the health of those who spent less appeared to be just as good as those who spent more.

The 45% higher per capita expense on the free plan had modest benefits for the poor. For example, under the free plan, low-income hypertensives enjoyed better blood pressure control, and had an associated gain in predicted

mortality. Yet, further analysis showed that the improvement in blood pressure control was primarily due to the initial screening examination."⁴¹ In fact, almost all of the beneficial effects of free care were for conditions that were relatively common, could be detected with relatively inexpensive diagnostic tests."⁴² Insurance that provided free medical care was a very expensive way to discover and treat these problems.

In all, the RAND Health Insurance Experiment showed that the average consumer spent far less on medical care when he was spending his own money, and that he chose reductions that were not harmful to health in any measurable fashion. As Table 2 shows, emergency room visits responded robustly to cost sharing. People who were paying for their own care reduced visits for conditions that can safely be endured while waiting to see a physician during normal business hours. Cost sharing had little effect on visits for serious problems likely to require immediate attention — head injuries, abdominal disease, chest pain/acute heart disease, and acute eye injuries.

**TABLE 2 RAND HEALTH EXPERIMENT EMERGENCY DEPARTMENT USAGE:
(BY INSURANCE PLAN AND DIAGNOSIS)**

Annual Visits per 10,000 persons			
	Cost-sharing plans	Free Plan	Cost-sharing visits as proportion of free plan visits
More urgent diagnoses			
Fracture/dislocation	134	168	0.80
Head injury	36	33	1.09
Surgical abdominal disease	42	38	1.11
Asthma	30	83	0.36
Ear infection	40	78	0.51
Chest pain/acute heart disease	59	57	1.04
Urinary tract infection	22	43	0.51
Acute eye injury	34	31	1.01
Burn, second degree/complicated	19	22	0.86
Less Urgent diagnoses			
Abrasion/contusion	228	403	0.54
Sprain	164	249	0.63
Gastroenteritis/diarrhea	36	67	0.62
Headache	8	59	0.11
Influenza/viral syndrome	40	61	0.65

Source: Joseph P. Newhouse. 1996. *Free For All?* Harvard University Press, Table 5.3 p. 155.

The fact that patients reduced costs by limiting the number of contacts with health care providers means that encouraging consumers to make more out-of-pocket payments for health care has the potential to significantly reduce U.S. health care spending by reducing utilization.

SPENDING TAKES OFF; OUT-OF-POCKET COSTS DECLINE

Historically, of course, out-of-pocket payments have almost become an endangered species in U.S. health care. As private insurance plans modeled after the Blue Cross Blue Shield plans spread and added more benefits to take

advantages of their tax-free status, U.S. consumers have controlled a dwindling fraction of the money spent on their health care. The passage of Medicare and Medicaid increased the government share of health spending. Medical expenditures exploded as they lowered the direct price that consumers paid for medical care. Between 1950 and 1975, the share of U.S. health care expenditures paid for by third party payers — either private insurance or government entitlement programs — rose from 12% to 41%. Private expenditures on health care grew from \$8.7 billion to \$59.8 billion. Government expenditures on Medicare and Medicaid rose from \$2.5 billion to over \$37 billion. During the same period, the percentage of GNP devoted to medical care rose from 4% to 11%.⁴³

**TABLE 3 NATIONAL HEALTH EXPENDITURES FOR THE UNITED STATES
By SOURCE OF FUNDS, BILLIONS OF DOLLARS**

	1970	1980	1990	1993	1999	2000	2001	2004
National Health Expenditures	75.1	254.9	717.3	916.5	1,207.3	1,358.5	1,474.2	1,877.6
All Government	28.3	107.3	290.0	402.3	560.0	602.2	667.0	847.3
Medicare	7.7	37.4	110.2	148.3	213.6	224.4	241.9	309.0
Medicaid	12.9	26	73.6	121.6	186.0	202.4	224.2	290.9*
All Private	46.8	147.6	427.3	514.2	710.2	756.3	807.2	1,030.3
Private out-of-pocket (OOP)	25.1	58.2	137.3	146.9	184.4	194.7	205.5	235.7
Percent OOP	55%	41%	33%	30%	28%	27%	26%	23%
Percent Health Expenditures	(Amounts may not add due to rounding)							
Government	37.7%	42.1%	40.4%	43.9%	44.1%	44.3%	45.2%	45.1%
Private	62.3%	57.9%	59.6%	56.1%	55.9%	55.7%	54.8%	55.8%

Sources: Levit et al.2001. "Trends in U.S. Health Care Spending," Health Affairs, January/February 2003 and U.S. Department of Commerce, Bureau of Economic Analysis, National Health Expenditures, Selected Calendar Years, 1960-2004.

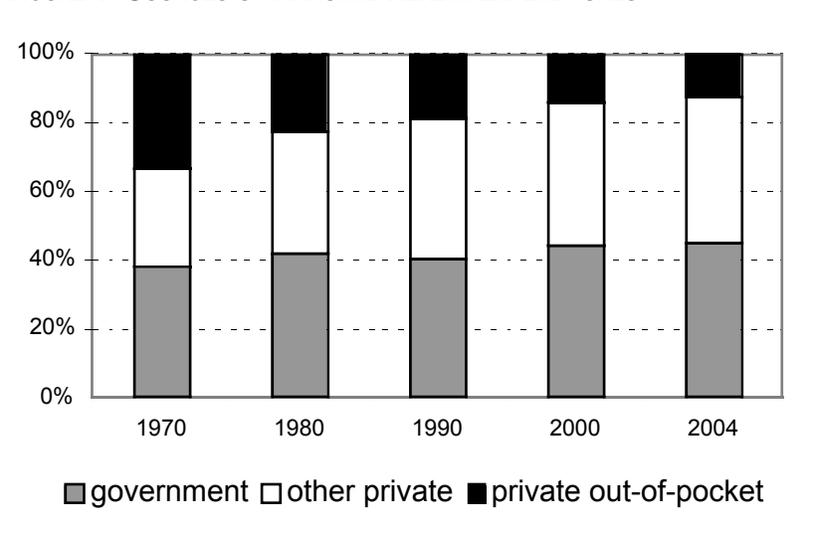
* Figure does not include spending on Medicaid buy-in agreements run by some states. Also excludes expenditures on Medicaid SCHIP Expansion and SCHIP, maternal and child health and alcoholism, drug abuse and mental health.

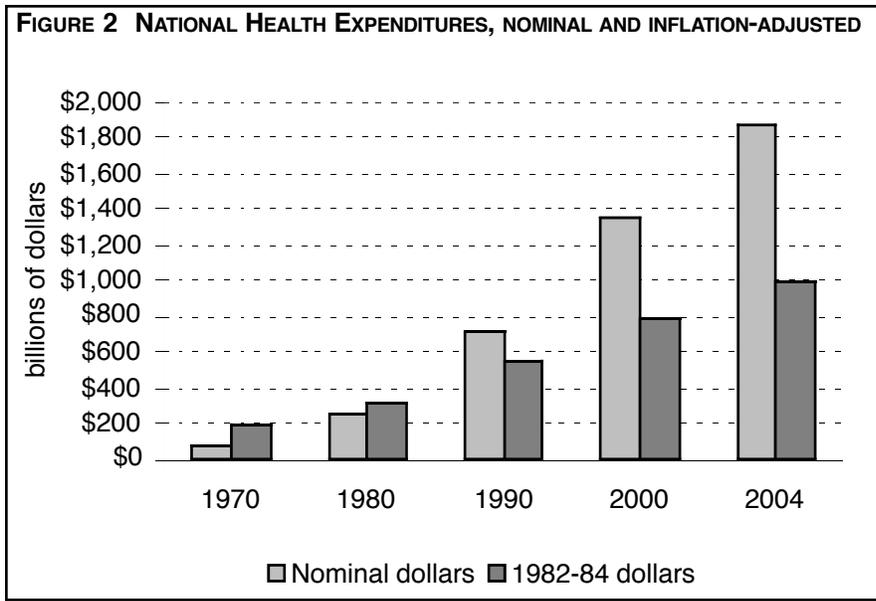
Table 3 shows that overall U.S. spending for health care increased substantially after 1970. The fraction paid for by government entitlements rose from almost 38% to more than 45%. Direct consumer payments fell from 55% of all private spending to 23% of all private spending.

The decrease in out-of-pocket spending was not due to a simple expansion of spending for hospital care over and above deductibles. As a fraction of national health expenditures, private out-of-pocket spending was 33% of all spending in 1970. By 2004, it had fallen to 13% even though inflation-adjusted personal consumption expenditures had risen from \$2,452 billion in 1970 to \$7,632 billion in 2004.

Figure 1 shows the percentage of U.S. health expenditures paid for by the private sector insurance, government, and consumer out-of-pocket payments. The amount of health care U.S. consumers paid for out-of-

FIGURE 1 SOURCES OF NATIONAL HEALTH EXPENDITURES





pocket fell substantially between 1970 and 2004 when measured as a percentage of total spending. Out-of pocket spending accounted for about 33% of total health care spending in 1970. It was only 12.5% of the total by 2004.

In addition to encouraging consumers to pay more, the switch to third party payment changed the behavior of charities. As government spending grew and individual payments for medical care fell, many non-profit groups stopped using their funds to pay medical bills for the needy, and turned instead to funding sup-

port to groups that lobbied for increased government spending on systemic reforms that would benefit their favored constituencies.

SPENDING GROWTH IN OTHER INDUSTRIALIZED COUNTRIES OUTPACES THAT IN U.S.

Although U.S. health spending has grown rapidly, it is important to keep its growth rate in perspective. The 1970s were a period of rapid inflation in the United States. Spending comparisons with past periods that fail to take that inflation into account exaggerate the rise in health spending. Roughly taking inflation into account using the consumer price index rather than the medical price deflator or the GDP deflator, United States spending on health rose by a factor of 10 between 1970 and 2004. Figure 2 shows the growth in U.S. health spending in both nominal and inflation-adjusted terms.

Despite the massive growth in the regulatory burden created by Medicare and Medicaid, and the rapid growth of demand fueled by technology, increasing wealth, and public entitlement programs, the percentage growth in U.S. health care spending has been unremarkable relative to that in other industrialized countries. Table 4 shows inflation-adjusted per capita health spending for selected Organization for Economic Cooperation and Development (OECD) countries for three decades beginning in 1970. In 1970-1980 and 1990-2001, the growth in U.S. health expenditures was below average. It was considerably above average in 1980-1990, at least partly fueled by the explosion of new medical technologies and their rapid adoption in the U.S. Even though U.S. out-of-pocket spending as a percentage of total household consumption is on par with a number of countries that have government-controlled health care systems, both it and South Korea are distinguished by the relatively large role the private sector plays in allocating their health care dollars.⁴⁴

OECD data like those shown in Table 5 (on page 16) are often used by health policy commentators in out-of-context comparisons of U.S. health spending with that of other industrialized countries. The inevitable conclusion is that the U.S. "spends too much on health care." The commentary typically ignores the fact that U.S. per capita GDP is 23% higher than Canada's and 36% higher than Germany's. Wealthier people spend more on many things, including entertainment, housing, vacation travel, transportation, and health care. Though U.S. citizens undoubtedly spend more than they need to on health care due to a regulatory thicket that imposes tremendous inefficiency on U.S. health and health financing, part of the additional spending would occur simply because U.S. citizens have more to spend and want to spend it on health care that preserves life and improves its quality.

To provide context for U.S. health spending, consider U.S. spending on education, also shown in Table 5. Partly due to wealth and partly due to waste, U.S. spending on education is higher than anywhere else in the world. It follows that those who cite high U.S. health spending as evidence that the U.S. spends too much on health care should also cite high U.S. spending on education as evidence that the U.S. also spends too much on education.

**TABLE 4 INFLATION-ADJUSTED PER CAPITA GROWTH IN HEALTH EXPENDITURES, OECD 1970-2001
PRIVATE SPENDING AS A PERCENTAGE OF TOTAL SPENDING, AND
OUT-OF-POCKET PAYMENTS (OOP) AS PERCENT OF TOTAL HOUSEHOLD CONSUMPTION**

	1970-1980	1980-1990	1990-2001	1990 % private	2000 % private	1990 OOP %	2000 OOP %
OECD average*	6.0	3.0	3.4	26	28	2.4	2.8
Australia	5.2	2.6	3.8	33	31	2.2	2.7
Austria	7.4	1.4	2.6	27	31	NA	2.7
Belgium	8.1	3.4	3.5	NA	28	NA	NA
Canada	3.2	4.0	2.3	26	29	2.4	2.7
Denmark	2.9	0.8	1.9	3	9	2.8	2.8
Finland	4.6	4.8	0.5	16	25	2.5	2.9
France	NA	NA	2.5	23	24	1.8	1.8
Germany	6.2	1.8	2.0	24	25	1.8	2.0
Ireland	8.5	0.1	6.7	28	27	1.8	1.9
Italy	NA	NA	1.9	21	27	2.1	3.1
Japan	7.1	2.6	3.8	22	22	NA	2.3
Korea	NA	NA	7.4	63	56	4.9	4.3
Netherlands	NA	2.3	3.1	33	37	NA	1.6
New Zealand	2.1	2.9	3.0	18	22	1.7	2.1
Norway	9.1	3.1	3.2	17	15	2.4	2.7
Spain	6.9	4.7	3.4	21	28	2.2 ('91)	3.0
Sweden	4.4	1.1	2.1	10	15	NA	NA
Switzerland	4.1	2.7	2.4	48	44	5.5	6.1
United Kingdom	4.1	3.2	4.2	16	19	1.1	NA
United States	4.5	5.5	3.2	60	56	3.6	2.9

Source: Manfred Huber and Eva Orosz. Fall 2003. "Health Expenditure Trends in OECD Countries, 1990-2001." Health Care Financing Review, 25, 1. *1970-90 averages exclude 11 countries, later average excludes 2. Highest is shown.

HIGHER AMERICAN SPENDING PRODUCES BETTER HEALTH CARE

The major difference between U.S. spending on health and U.S. spending on education is that a majority of health spending still takes place in the private sector. Educational spending, even at universities, is largely controlled by government. The extent of government control matters. High spending on primary and secondary education produces 15-year-old Americans that consistently rank in the bottom third on international achievement tests. In contrast, high spending on U.S. health care produces significant benefits for American patients.

Private control makes it more likely that funds will be channeled to areas important to consumers. When the spending is on health, the money flows to patient care. In privately-controlled systems, infrastructures end up designed to cure maladies, promote full recoveries, and shorten treatment times. People willingly pay for prompt care, diagnostic tests to lower their risk, on drugs and devices that ease compliance with medical regimes, and for research into treatment modalities likely to cure disease and dysfunction.

TABLE 5

	Per capita GDP, 2003 (US\$, PPP)	Health Spending, 2003			Education Spending, 2005		
		As % GDP 2003	Per capita 2003, US\$	Average GrowthRate 1998-2003	As % GDP 2005	Per Student College, US\$	Per Student Primary, US\$
United States	37,624	15.0	5,635	4.6%	7.3	22,234	7,560
Canada*	30,475	9.9	3,003	4.2%	6.1	***	***
United Kingdom	29,931	7.7	2,231	5.7%	5.5	10,753	4,415
Germany	27,565	11.1	2,996	1.8%	5.3	10,504	4,237
France	28,200	10.1	2,903	3.5%	6.0	8,837	4,777
Japan*	28,016	7.9	2,139	3.0%	4.6	11,164	5,771
Sweden**	28,987	9.2	2,594	5.4%	6.5	15,188	6,295

Source: Organization for Economic Cooperation and Development.

*estimates.

**2002 for health care measures, 2003 for education.

In politically-controlled systems, money flows to issues of concern to politicians. At any one time, less than 5% of the population in most industrialized countries needs sophisticated medical care. In terms of votes, the concerns of the sick are inevitably outnumbered by the concerns of the well.

The private U.S. health sector has rapidly adopted new therapies and continuously upgraded its facilities. With the possible exception of those dependent on government payment, patients have ready access to new and more effective treatments. La Vecchia, et al. compared survival rates from childhood cancers in North America, western Europe, Japan, Australia, and New Zealand. Given that the incidence of childhood cancers has not changed over the last thirty years, they concluded that any reduction in mortality would be a result of a country's advances in medical care and could serve as one measure of health system effectiveness in developed countries."⁴⁵

TABLE 6 COMPARATIVE CANCER SURVIVAL RATES

	5 year survival rates	
	Europe	U.S.
Prostate	56%	81%
Skin melanoma	76%	86%
Colon	47%	60%
Rectum	43%	57%
Breast	73%	82%
Uterine	73%	83%

Source: Gatta et al. August 15, 2000. "Toward a comparison of survival in American and European Cancer Patients, Cancer, 89, 4.

As Table 6 shows, adults with cancer also have a better prognosis in the United States. In 2000, Gatta et al. reported relative survival rates using data on twelve cancers from cancer registries in seventeen countries after correcting for competing causes of mortality.

The aggressive treatment used in the U.S. may also be of benefit. Recent data suggest that the aggressive treatment offered U.S. cardiac patients improves both their survival and their functioning relative to the less costly treatments that are standard in Canada.

Heart attack patients enrolled in GUSTO (Global Utilization of Streptokinase and Tissue Plasminogen Activator for Occluded Coronary Arteries) were followed for five years. The differential procedure rates indicate the large differences in patient care prevailing in the U.S. and Canada. At one year, the "rates of cardiac catheterization were 78.8% among U.S. patients and

42.0% among Canadian patients," "angioplasty rates were 36.5% in the United States and 16.5% in Canada," and "bypass surgery rates were 19.5% in the United States and 9.3% in Canada." Canada had a slightly higher mortality rate at one year. By the end of five years, the U.S. mortality rate was 19.6%. The Canadian mortality rate was 21.4%.⁴⁶

The U.S. also enjoys better population blood pressure control than nations with socialized care, perhaps because it spends more on drugs, physician visits, and specialists. In Europe, researchers measured "a steeper increase in [blood pressure] with advancing age"⁴⁷ and a 60% higher prevalence of hypertension."⁴⁸

High U.S. spending also purchases the world's lowest infant mortality rates. For years, commentators have routinely argued that the poor U.S. performance in OECD comparisons of infant mortality rates shows that the U.S. health care system produces substandard results at great expense. A closer examination of the data showed that the OECD numbers were biased against the U.S.

Higher U.S. spending may also make chronically ill Americans better off. After twenty years of living with spinal cord injuries, there were "fewer health and disability related problems" among an American sample of spinal cord injury patients than among comparable samples from Canada and Britain.⁴⁹

Private control may also make hospitals a safer place. In a 2004 paper in the *Canadian Medical Association Journal (CMAJ)*, Canadian researchers reported on the results of the adverse event studies in various countries. Adverse events are defined as "an unintended injury or complication resulting in death, disability or prolonged hospital stay caused by health care management." Their results are reported in Table 7 and suggest, subject to sample limitations and the tentative nature of the studies, that higher U.S. spending also buys significantly safer hospitals. This conclusion is buttressed by reports of appalling hospital conditions in the British and Canadian press.

TABLE 7: INTERNATIONAL COMPARISONS OF ADVERSE EVENTS IN HOSPITAL PATIENTS

Author, Location, Year	Percent of patients with Adverse Events	Number of hospitals (patient observations)
Baker, Canada, 2000	7.5	20 (n=3,745)
Thomas, Utah Colorado, 1992	2.9	28 (n=14,700)
Wilson, Australia, 1992	16.6*	28 (n=14,179)
Brennan, New York City, 1984	3.7	51 (n=30,195)
Vincent, London, 1999-2000	10.8	2 (n=1,014)
Davis, New Zealand, 1998	12.9*	13 (6,579)

Source: Baker et al. May 25, 2004. "The Canadian Adverse Events Study: the Incidence of Adverse Events Among Hospital Patients in Canada," *CMAJ*, 170, 11, 1678-1686.

*Looser definition of causation could include more events. When Thomas et al. harmonized the U.S. and Australian inclusion data the revised estimates produced Australian adverse event rates of 10.6 percent.

Waiting Lists Kill and Do Not Appear Susceptible to Known Management Techniques

Also important for better care, better survival rates, and lower rates of disability, is the fact that U.S. residents have virtually immediate access to sophisticated medical care. In Canada, patients must see a general practitioner for referral to a specialist. Because the government sets prices and budgets for physician visits, physicians see patients until they exhaust their budgets.

The Canadian physician shortage is such that an estimated 4 million people, out of a population of 32 million, cannot find a primary physician willing to treat them. They access the system through over-crowded emergency rooms.⁵⁰ Those who do have physicians wait weeks or months for their specialist appointment, weeks or months for the diagnostic tests ordered by the specialist, and then weeks or months for recommended treatment. In some cases, even entry by emergency room is closed. On June 20, 2002, Claude Dufresne died of a heart attack when a Shawinigan, Quebec, emergency department said it closed at midnight and refused to admit him even though a physician was present. His ambulance was directed to another hospital about 30 minutes away. Mr. Dufresne died en route.⁵¹

In 1999, the Vancouver-based Fraser Institute reported that 121 patients waiting for bypass surgery in Ontario had been removed from the waiting list because their disease had progressed while they were waiting, and they were

now judged to be too ill to withstand surgery. The risk of death increases significantly with waiting time, rising by 11% for every month spent in the queue.⁵²

Table 8 shows that national waiting lists have been growing despite government programs to reduce them. Careful study of the matter suggests that the lists will not be eliminated simply by allocating more money to health care. When

TABLE 8 PERCENTAGE OF PATIENTS WAITING MORE THAN 4 MONTHS FOR ELECTIVE SURGERY

	1998	2001
Australia	17	23
Canada	12	27
New Zealand	22	26
United Kingdom	33	38
United States	1	5

Source: R.J. Blendon et al. 2002. "Inequities in Health Care, A Five Country Survey," *Health Affairs*, 21,3, 182-191 as cited in Jeremy Hurst and Luigi Siciliani. July 7, 2003. Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries, Health Working Paper No. 6, Organization for Economic Co-operation and Development, Paris, France. p. 12.

governments set prices and budgets for various health care services, they inevitably create systemic resource allocation problems at local levels. These errors are invisible to system planners. In private systems, resources are allocated as local actors see fit. In public ones, physicians and patients must wait for the bureaucracy to command information, compile it, study it, and make decisions. By the time the bureaucratic process finishes its cycle, much relevant information has been lost and events may have rendered the offered solution obsolete or unworkable.

A 2002 paper by Feachem, Sekhri, and White vividly illustrates the differences in care that result when management is private rather than governmental. The authors compared costs and quality for California's Kaiser Permanente and Britain's National Health Service (NHS). After carefully adjusting for differences in benefits, special activities, populations and the cost environment, the authors concluded that although the per capita costs incurred by the two organizations were within 10% of one another, the "Kaiser members experience more comprehensive and convenient primary care services and much more rapid access to spe-

cialist services and hospital admissions." They also concluded that the "widely held beliefs that the NHS is efficient and that poor performance in certain areas is largely explained by underinvestment are not supported by this analysis. Kaiser achieved better performance at roughly the same cost as the NHS. . . ."⁵³ Kaiser simply managed its resources better, allocating hospital beds more efficiently, making better use of highly trained specialists, and providing well-equipped physicians who could do what was needed in a single visit.

Government-run health systems also incur largely invisible deadweight losses from the high taxes required to pay for them. When these losses are accounted for, the costs of administration rise considerably. Patricia Danzon's rough estimate for the Canadian health system in 1992 suggested that when all costs were considered, public insurance in Canada had overhead costs greater than 45%. U.S. private insurers had net costs of about 8%.

HEALTH POLICY EXPERTS EMBRACE CENTRALIZED CONTROL IN AN EFFORT TO CONTROL COSTS

As the RAND Health Insurance Experiment ended in 1982 and health care costs were rising more rapidly than expected, the federal government began trying to control its costs. Rather than increase the consumer role in Medicaid and Medicare spending by imitating successful federal programs like Food Stamps, it opted for price controls and managed care — central planning by another name. It rearranged the legal environment to remove more health care decisions from individual control. The theory was that the U.S. medical system was fraught with waste, and that deploying legions of utilization review experts would bring down costs by rationalizing the system.

Initial efforts to promote central planning were driven by the idea that physicians were prescribing unnecessary tests, and that patients were too demanding in their desire to be treated at their convenience with the latest medical technology. In the 1970s, the federal government passed legislation giving states the right to impose certificate of need laws (CON) which gave states the power to veto both private hospital construction and the private acquisition of new and expensive medical equipment, primarily CAT scanners and MRIs. Little attention was paid to the fact that advanced diagnostic devices reduced the need for exploratory surgery or that steady technological progress would ultimately reduce costs.

Economists who specialized in regulation generally agreed that certificate of need laws would increase the cost of new capital equipment by diverting resources to firms that generated the volumes of paperwork needed to convince distant bureaucrats that what people working in the industry said they needed was actually needed. They also raised prices by creating protected markets. Because the first group to place a CAT scanner in a new market had no competition, it could charge premium prices for the use of its machine. It was worth its while to pay significant amounts to protect its monopoly positions, usually by arguing that any additional machine was unnecessary and would add to costs.

The 1970s belief that more capacity increases prices is still current in Wisconsin health policy circles. A 2005 *Milwaukee Journal Sentinel* article on the value of competition in health care said that Concerned Business for Responsible Health Care coalition members were against building a new hospital because “Aurora’s proposed hospital would drive up costs by duplicating existing services.”⁵⁴

If it were true that every new facility simply increases costs, the 2004 closure of the for-profit, privately-owned Heart Hospital of Milwaukee after a year of operation would not have happened. As in other sectors of the economy, producers in health care cannot simply raise prices to cover excess capacity. This, along with more than a decade of economics research suggests that certificate of need laws probably increase overall costs by impeding price adjustments and by adding a layer of regulatory interference. In response, most states have repealed their certificate of need laws.

Regulations Favor Utilization Controls, Health Maintenance Organizations

Along with certificate of need laws, the federal government embraced managed care as a cost control measure, tilting federal health policy towards Health Maintenance Organizations (HMOs) with the passage of Senator Edward Kennedy’s (D-Mass) 1973 HMO Act. Federal agencies were formed to aid in the development of HMOs. To artificially create a market for services that few people at the time wanted, businesses with more than 25 employees were required to offer an HMO option under their health insurance plans. According to John C. Goodman and Gerald L. Musgrave, HMO premiums accounted for just 2% of all health insurance premiums in 1962. Federal insistence on adopting the HMO model of care delivery resulted in rapid growth in HMO membership rising from 5% in 1980 to 46% by 1996, of the total insured population under age 65.⁵⁵

Health Maintenance Organizations differ from standard indemnity insurance and from preferred provider organizations (PPOs) because they combine the physician and the insurer in a single organization. Patients pay a flat fee for their health care, a capitated payment, and the HMO promises to provide all of the health care an individual needs. A conflict of interest is built into HMO structure: HMO physicians work for the insurer, not for the patient.

While PPOs may levy a financial penalty for going out of the networks, most still offer some financial coverage if people decide to visit unapproved physicians or contract for medical care at prices that exceed reasonable and customary charges. HMOs do not. People who contract with HMOs are effectively uninsured if they seek medical care that their HMO cannot or will not provide.

HMOs were said to be preferable to traditional indemnity insurance arrangements because the capitated payment gave them an incentive to keep their members healthy, and because their utilization controls would reduce the unnecessary medical care that everyone assumed was rampant. Early studies suggested that this hypothesis might be true, though most were unable to adjust for the possibility that healthier people tended to prefer HMOs or that HMOs consciously marketed their services to healthier people. More recent statistical work has tried to adjust for possible differences in group health status. Its results suggest that policies promoting the stringent utilization control common to HMOs may be problematic for sicker people.

Medicare Turns to Price Controls

In 1983, Medicare imposed de facto price controls on medical care by adopting a prospective payment system. Prospective payment meant that hospitals would be paid a flat fee determined by Medicare for each patient based on which of 467 diagnosis-related groups (DRG) his case fit into. The government paid the DRG rate regardless of the actual amount of medical care consumed by a particular individual required. DRGs were billed as a market-based

means for making hospitals more efficient. As many people at the time realized, they were nothing of the sort. Contemporary analysts predicted that they would lower quality, divert substantial resources to gaming the price system, and politicize the health care system by creating incentives for an endless parade of special interests to lobby for special treatment.⁵⁶

With its fixed price for any case with a given diagnosis, the prospective payment system instantly turned patients who cost more, generally those who were older, sicker, and frailer, into financial liabilities. Hospitals discharged patients “quicker but sicker,” shifting much of the burden of care and rehabilitation to nursing homes unconstrained by the new payments system. As providers learned to game the system, diagnoses with higher reimbursements increased, corrupting medical records. Intense lobbying efforts occurred to create DRGs that reflected costs in various specialties and treatments for various diseases. As of 2004, the number of DRGs had expanded to 526.⁵⁷

As a result of prospective payments, Fitzgerald, Moore, and Dittus found that between 1981 and 1986 the mean length of hospitalization for elderly patients with hip fracture decreased from 21.9 to 12.6 days and the maximal distance walked before discharge fell from 93 to 38 feet. The proportion of patients discharged to nursing homes rose from 38% to 60%, and the proportion of patients who were still in a nursing home one year after their hip fracture also rose, from 9% to 33%.⁵⁸

Sicker but quicker discharges appear to have been the norm for patients with other conditions as well. In 1990, Kosecoff et al. developed measures of discharge impairment for five conditions before and after the imposition of prospective payments. They found that before prospective payments, 10% of patients discharged to their homes were unstable. After prospective payments, 15% of patients discharged to their homes were unstable. In general, unstable discharge was associated with a higher mortality rate; death in 16% of cases versus death in 10% of cases.⁵⁹

Although prospective payment undoubtedly reduced hospital use, it may well have done so at the expense of increasing overall costs. Unstable patients often have to be readmitted to hospitals, increasing the cost per case even as the number of days of hospitalization per admission falls. Writing in 1990, Keeler et al. looked at the U.S. system before and after prospective payments, finding that patients admitted to the hospital were much sicker after prospective payments than before. Captivated by what planners said should be happening, the authors figuratively scratched their heads, saying that the reasons for this were “not clear,” because under the new system hospitals should be encouraged to take healthier people.⁶⁰ They did not consider the possibility that the sicker patient population was an artifact of multiple readmissions.

As one would expect, studies looking at elderly mortality after the institution of prospective payments found it generally unchanged. In part, this may have reflected the fact that more care was shifted to nursing homes, which were still paid for services rendered. People did not die; they just suffered from more disability. Despite the early findings about prospective payments, they were extended to physicians in 1992-1996 as part of the Clinton administration drive to recreate the U.S. health care system in the image of European ones. Prospective payment has since been extended to skilled nursing facilities, inpatient rehabilitation facilities, and home health care providers without any plan for monitoring its systemic effects.

The results have been predictable. Frymark and Mullen looked at the effect of prospective payment on in-patient therapy for patients who had cognitive problems and problems communicating and swallowing. They found that prospective payment increased the number of people discharged with less than adequate functional skills.⁶¹

As the government strives to keep up with the dislocations created by price controls and their compounding inefficiencies, Medicare’s increasingly Byzantine arrangements are made workable by continuous tinkering with its mind-numbingly complex annual adjustments. In 2006, Medicare introduced All Patient Refined Diagnosis Related Groups (APR-DRGs) to adjust for severity of illness. This has promoted rounds of discussions over such important patient care issues as whether patients who are in the hospital with severe sepsis and have become sick enough to be on a ventilator are or are not in a DRG that reflects the costs of using a ventilator.

The level of annual effort devoted to the health systems coding and pricing problems is reminiscent of the army of central planners fielded by the Soviet Union. The 2005 Medicare hospital inpatient prospective payment final rule discusses changes in DRG groups themselves, relative weights, wage data, labor-related shares of the wage index, geographic area designations used to calculate the wage index, changes in threshold criteria for approving new medical and technological inclusions in coverage and add-on services, changes in policies governing post-acute care transfers, changes in payments to hospitals for the costs of graduate medical education, changes in payments for disproportionate share rural hospitals, changes in payments to critical access hospitals, and, last but not least, changes in the hospital conditions of participation for discharge planning and fire safety requirements for certain health care facilities.⁶²

With the exception of the very wealthy who can travel abroad for care or pay cash to physicians and hospitals that have opted out of Medicare, the U.S. government exercises almost complete control over all aspects of health care for U.S. citizens over 65. After two decades of grafting clumsy cost controls onto an already faltering system of reimbursement that dates back to the 1930s, Medicare now consists of a disconnected set of price controls on each small piece of the process used to treat a particular malady.

There is no mechanism to consider whether Medicare's regulatory oversight produces a sensible whole for a particular patient. There is no mechanism for determining that in Patient A's case more acute care spending would save money by stabilizing him to the point where he could skip a nursing home, with its chance of infection, and go straight home. No one knows whether separate prospective payments for physicians, acute care, skilled nursing, and home care makes sense or merely increases total costs by encouraging providers to play a game of hot potato with sick patients that pose a threat to their financial viability.

THE SEARCH FOR QUALITY MEASURES TO REPLACE CONSUMERS

Consumers faced with buying goods that they aren't particularly knowledgeable about, whether higher education, legal services, car repair, computer programming, or home repairs, often hire an expert to help get the best value for their money. In medicine this has historically been a private physician who works for a patient. Local physicians knew local hospitals. They also knew specialists in their area and could make informed judgments about them. Patients who felt they were getting bad advice were free to make appointments with other physicians to get other outlooks. Hospitals served as a check on physicians, denying privileges to doctors who did not meet their standards. Professional societies determined consensus standards of clinical treatment. Patients unhappy with one physician were free to hire another. The system was not without its flaws, as professionals tend to protect one another, but history has shown that it did ensure a minimum level of quality in ways that bureaucratic commissions, like the British National Institute for Health and Clinical Excellence (NICE), do not.

In the 1990s, the health policy establishment began treating physicians almost as an adversary of the patient, generally claiming that they padded their income by recommending unnecessary tests and procedures. Its antidote for the physician menace was managed care, an arrangement in which physician decisions had to be approved by third party payers. Insurers controlled physician choice, the treatments used by a physician after a diagnosis was made, and the hospitals and specialists that could provide care. Clinical pathways were designed specifying rigid systems of proper treatment for each known disease, and financial penalties and legal or disciplinary actions threatened providers who violated them. The role of the physician in quality control diminished.

Financial penalties were also assessed on patients who disagreed with insurer judgments and chose to go out of the network of hospitals and physicians who agreed to abide by an insurers care pathways. Private third party payers adopted prospective payment systems of their own, though they paid higher rates than Medicare or Medicaid, and built networks of physicians and hospitals based on price. As both private insurers and government migrated to more centralized control of medical decisions, it became increasingly difficult to tell whether a given physician was working for a patient or his insurer. This undermined the traditional system of quality assurance.

Like the push for utilization controls, the push to create measures that tied financial reimbursement to actual medical practice was aided by policy activists. A strategically released Institute of Medicine (IOM) book, *To Err Is Human*, was published in 2000 to make the case for a vast expansion in statistical quality measures. The IOM report claimed that "medical injuries account for between 48,000 and 98,000 deaths per year in the United States . . . ahead of breast cancer, AIDS, or motor vehicle accidents" and repeatedly claimed that nationally verifiable quality of care measurements were needed to protect patients.

That the IOM study was activism at its best was confirmed by when expert review determined that the results from the two studies of medical care errors that were the basis of the IOM report were misrepresented. Cox and Woloshin reviewed the IOM documentation backing its estimates and concluded that they "could not confirm the Institute of Medicine's reported number of deaths due to medical errors."⁶³ Troyan A. Brennan of Boston's Brigham and Women's Hospital, the author of one of the studies used to make the estimates, wrote that "neither study cited by the IOM as the source of data on the incidence of injuries due to medical care involved judgments by the physicians reviewing medical records about whether the injuries were caused by errors. Indeed, there is no evidence that such judgments can be made reliably."⁶⁴ He also characterized the IOM recommendations as "giv[ing] the impres-

sion that doctors and hospitals are doing very little about the problem of injuries caused by medical care . . . yet the evidence suggests that safety has improved, not deteriorated.”

In an article in *JAMA*, McDonald et al. noted that the IOM figure of 98,000 deaths was extrapolated from the Harvard Medical Practice study.⁶⁵ Unfortunately, the original publicity accompanying the release of the IOM study permanently implanted the idea of enormous error rates in the public mind. The furor was such that few questioned the new fad for the quality measures that were rapidly rolled out of foundations, government, and think tanks committed to the regulatory project. The result has been the rapid institutionalization of a number of poorly tested quality measures — many of which are as reliable as the IOM report — that promise to make their nonprofit sponsors a great deal of money, and have at best a dubious relationship to outcomes of primary concern to patients.

A classic example of the mischief caused by inappropriate quality measures is Medicare’s decision to use resident falls as an indicator of the quality of care in nursing homes. In response, many nursing homes have aggressively moved to prevent falls. Residents are not allowed to get up and move around without supervision. Alarms go off if they try to get up. As a result of an arbitrary quality measure, people are discouraged from moving around, a measure as likely to harm their health as protect it.

Quality measures also include the forcible imposition of a variety of computerized data entry and control systems in hospitals and physician offices. In Pittsburgh, the implementation of a computerized physician order entry system was associated with an increase in mortality from 2.8% to 6.8% among pediatric cases transported to an academic tertiary care hospital.⁶⁶ There is also large accompanying literature documenting the role of computerized order entry systems in facilitating medication errors.⁶⁷

Quality Measures That Kill

On close examination, most of the clinical guidelines, pay for performance measures, and other reporting requirements used to measure quality have one distressing characteristic in common: no one knows if they are related to health outcomes that matter in any given individual. Added to this uncertainty is the fact that the data underlying many quality measures are of dubious quality and the fact that the measures themselves are so numerous that it is generally impossible to combine them in any meaningful way. When Boyd et al. tried to apply current clinical practice guidelines for various diseases to a hypothetical 75-year-old woman with five common problems, they concluded that existing quality recommendations were virtually unworkable in real patients.⁶⁸

What public quality measure proponents leave out is the fact that later studies have shown that the mortality gains from the report cards may have come from refusing to treat sicker patients. As Turi put it in 2005, “individual physicians and hospitals as a whole appear to be declining to provide aggressive, potentially life-saving care for some higher-risk patients” in order to look good in the ratings.” “[I]n addition to the medical-legal risk shouldered by physicians and institutions when managing high-risk patients (lawsuits predicated on bad outcomes, not necessarily bad management), now each patient also represents a public relations and economic risk as well.”⁶⁹

Over half of New York cardiac surgeons in one survey reported refusing to perform surgery on at least one patient due to public reporting. In the eight years before public reporting, patients referred to the Cleveland Clinic from New York State were comparable to those from other states. Immediately after public reporting began in New York, the population of cardiac patients referred to the Clinic from New York grew and began to contain significantly sicker people.⁷⁰ In 2005, Moscucci et al. compared age-adjusted in-hospital mortality rates following cardiac surgery in New York state and Michigan, which has no reporting requirements. They found that Michigan patients were four times more likely to receive angioplasty when having a severe heart attack. They were also more likely to be operated on when they had cardiogenic shock, congestive heart failure, and extracardiac vascular disease. Although the death rate was much lower in New York, the difference was due to the fact that patients in Michigan were sicker.⁷¹ In view of this, it is perhaps no accident that New Yorkers are more likely to die of heart attacks than people from other states.

As expenditures have continued to spiral upwards despite 25 years of utilization review, managed care constraints, and prospective payments, some people rationalize denying care to “high cost” patients in the name of reducing cost growth. The problem is that this has already been tried in Europe. It has done nothing to control government expenditure on health care.

Does Central Planning Reduce Cost?

Despite utilization controls, price controls, and an increasing propensity for government to run the U.S. health care system, rising health care expenses continue to subject both business and government budgets to unprecedented stress. In 2004, Medicare expenditures of \$308.9 billion represented about 2.6% of the U.S. GDP. Without reform, they are expected to rise to 6.7% of GDP by 2030 and to 9.2% of GDP by 2050. For comparison, the entire 2004 federal budget consumed about 20% of GDP. Of that, spending on national defense was almost 4% of GDP. The projected increase in Medicare expenses for people already born is equivalent to a doubling of the defense budget.⁷² Medicaid is now a more expensive program than Medicare.

Although the effect of the prospective payments system is generally unknown, past experience with Medicare program growth does not provide much hope for the future. With the exception of the late 1990s, when Medicare costs actually fell after the changes embodied in the 1997 Balanced Budget Act, it has continued to grow robustly due to increases in the number of disabled beneficiaries, increased participation rate, average payments per service, and higher enrollment. Medicaid expenses are propelled by medical cost increases, program expansions, fraud, and an increase in long-term care.

THE PROMISE OF CONSUMER-DIRECTED CARE

Consumer-driven health care offers the most promise for improving quality and controlling costs. The concept was reinvented in the early 1980s when a number of pioneering health care policy experts began researching the feasibility of promoting individual self-insurance for relatively small medical bills and creating lifetime savings to deal with the health problems of old age.

The idea was to promote health insurance policies with large deductibles, policies that had substantially lower premiums and acted more like insurance than prepaid health care, and were directly owned by individuals rather than provided by employers. Policies like this were unavailable in many states because state regulations and mandates limited the size of deductibles.

In the U.S., the private health insurance market has traditionally been divided between federal and state regulated entities. The regulation of the business of health insurance has been the province of the states since 1945, and companies that offer nationwide health insurance must file with state authorities in every state in which they do business. States have traditionally taxed insurance companies operating within their borders, approved the plans that they market, set reserve requirements, and audited compliance.

Since 1974, larger employers have operated self-insured health plans under the federal Employee Retirement Income Security Act (ERISA). This frees them from state laws covering plan design and allows them to avoid the taxes levied on standard insurance companies. While many ERISA-plan businesses hire health insurance companies to administer their health plans and purchase reinsurance to cover big claims, very small employers find compliance too costly. Those that still offer group health insurance typically buy their health insurance policies from the health insurers allowed to do business in their states in what is known as the small group market. Individuals purchase health insurance policies in the individual market, one that states have traditionally treated separate from the small group market.

In the late 1980s and early 1990s ambitious private foundations like the Robert Wood Johnson Foundation began promising state officials cash grants in exchange for enacting model legislation designed to force employers to insure employees for virtually every medical expense. Governors were told that bad health occurred because people lacked access to health care. Better health care via insurance mandates would lower overall spending by correcting the lack of access, preventing disease, and lowering state public health bills. Correcting lack of access required removing financial barriers.

In practice these policies meant pushing legislative reforms that increased benefits by requiring extensive coverage for routine matters and lowered deductibles for the insured, reforms that eliminated any significant charge for care at the time of service either by providing free care or funding Medicaid expansions to those who were uninsured, uninsurable, and who had incomes at or below median income.

When made into law, the model plans turned health insurance into prepaid health care. By forcing consumers to buy health plans that pay for childhood vaccines, for example, legislators increased both the cost of health insurance

and the cost of childhood immunizations. Health insurance premiums must be high enough to pay for expected claims, operating costs, and profits. To pay for a vaccine costing \$50 in the physician's office, a consumer might have to pay \$60 in health insurance premiums. As premiums rose to reflect the rich array of benefits and low deductibles that were stuffed into the mandated policies, health insurance became a poor value. Healthy people began joining the ranks of the uninsured.

This strategy made sense thanks to various pieces of federal legislation that had already made having health insurance less important. As incomes rose, financial arrangements like home equity lines of credit gave ordinary families access to large amounts of emergency cash: people could and did pay cash for routine health care. Federally Qualified Health Centers, an outgrowth of the Community Health Centers established in the 1970s, provided free and low cost care to all and expanded to cover most of the country. The 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) ensured that anyone presenting at a hospital emergency room would be treated. Under EMTALA, all Medicare-participating hospitals were required to screen and treat anyone walking into an emergency room regardless of their ability to pay. With utilization controls increasing the wait for physician appointments in both public and private health programs, emergency rooms also provided a convenient way to see a doctor without having to wait weeks. Between 1993 and 2003, emergency room visits increased by an estimated 26%.⁷³

With so much free care available, any model health insurance legislation that increased the cost of insurance was destined to produce dismal results. And because ERISA employers were exempt, the costs of the state health insurance experiments fell primarily upon employees of small businesses. Under the community rating schemes designed to reduce state spending by ensuring that sick people could get private health insurance, healthy young employees paid high premiums to subsidize the costs for older, less healthy, ones. Since guaranteed issue let people defer buying health insurance until they actually had a serious illness, claims exceeded premiums and stayed that way. Health insurers left the small group market in droves. Regulation was so inept that states like New Jersey, Tennessee, and New York managed to make small group coverage unavailable in their states. Regulation of the individual insurance market was less intrusive, but insurers cowed by losses in the group market effectively stopped issuing individual policies to anyone with any history of even minor health problems.

By 1996, the disarray in state insurance markets was noticeable. It contributed to the passage of federal legislation allowing a pilot program authorizing the sale of 750,000 medical savings account (MSA) policies. The restrictions on who could buy them were so severe that just a tenth of that number was sold, and no large health insurers felt that the market was large enough to justify committing resources to developing products for it. Proponents of government controlled health care systems declared victory, claiming that the MSA experiment proved that consumers did not want policies with large deductibles. Other experts persisted in consumer-directed health reform efforts. In December 2002 Congress passed legislation creating tax free Health Savings Accounts.

Basically IRAs for medical care, Health Savings Accounts (HSA) are tax free savings accounts that can be used for any expense that the IRS deems health-related. They differ from flexible spending accounts (FSAs) and Health Reimbursement Accounts (HRAs) in that the holder of the account actually owns it and the money in it. The other benefit of an HSA is that IRS definitions of allowable health care spending are typically far more expansive than those of standard health policies. People can use HSA accounts for dental care, orthodontics, and other therapies not covered by their health insurance policy. They can also use it to save for long-term care in old age.

In order to have a health savings account, a person must be insured by a qualified high-deductible health plan (HDHP). Although HDHPs provide some first dollar coverage for preventive care and state-mandated services, their main feature is higher deductibles, with current minimums of \$1,000 for an individual and \$2,000 for a family. Total costs to an insured must be capped at \$5,100 for an individual and \$10,200 for a family, including both deductibles and copays. In return for the risk of accepting a higher deductible, people covered by HDHPs may deposit pre-tax dollars into their HSA. The annual deposit cannot exceed the amount of the deductible and is adjusted each year. Currently the maximum allowed amount is \$2,700 for single coverage and \$5,450 for family coverage.⁷⁴

Why HSAs Work

There are two theoretical reasons why widespread use of HSAs and HDHP health insurance can be expected to lower costs without degrading the quality of care. The first is administrative. In any given year, a very small fraction of the population has substantial medical expenses. This means that most households can afford to use cash to pay their medical bills, potentially eliminating the overhead cost implicit in processing multiple claims for routine care and low-dollar office visits. Many physicians currently give discounts of 20% to 30% to patients who pay cash, and cash-only physician practices, which forgo the back office expenses associated with tracking and collecting insurance claims, typically have fees substantially below those who participate in insurance networks.

Because higher deductible policies mean that insurers get involved only in more severe illnesses, they reduce claims expense. And if people make regular deposits to the savings account while they are young and healthy, the amount of cash available as they age can be significant. Suppose a family with a \$5,200 deductible and health expenses of \$2,100 in an average year regularly deposits \$5,200 in its health savings account, spends \$2,100 and has \$2,100 remaining at the end of each year. At a tax free interest rate of 3%, that family would have a balance of almost \$100,000 at the end of 30 years, enough to fund long-term care insurance and buy insurance to handle most medical emergencies. If they spent \$4,000 a year, the balance would still be \$22,000. Even if the family saved nothing because its expenses were equal to the deductible every single year, it could still be better off due to the fact that HDHP policies tend to have lower premiums than comparable standard policies and offer a wider choice of treatment options.

The second reason consumer-directed health plans are likely to save money is that people spending their own money tend to spend more carefully. They have more information about their situation than any third party, and they use it in actively looking for ways to save. Current real world experiments suggest that human nature has not changed since the RAND Health Insurance Experiment, and that even people who are chronically ill can cut costs if they have the freedom and incentive to do so.

In 2002, the State of Colorado began a pilot program that provided consumer-directed attendant support for about 146 severely disabled Medicaid patients. Under normal Medicaid rules, they were provided with home health aides supplied by agencies that billed Medicaid directly. The people being taken care of never saw the bills, there was no error checking, and patients had no control over the personnel being sent into their homes. The Colorado program turned the traditional logic on its head. Patients who participated were given a budget for home health care and the power to hire and fire their own aides. Average monthly spending for aides dropped by 21%, from \$3,925 to \$3,131. Care was better. Instances of abandonment dropped as did the number of thefts by caregivers. Patients split the savings 50/50 with the state, allowing them to buy needed equipment like voice-activated telephones. Colorado has since expanded the program to the disabled elderly receiving care at home.

Early business experience with consumer-directed health insurance is promising. In a survey released in January 2006, the Deloitte Center for Health Solutions reported that costs for consumer-driven health plans, either health savings accounts or health reimbursement arrangements, increased by 2.8% in 2005. HMOs had increases of 8%, point-of-service plans had increases of 8.5%, and preferred provider organizations had increases of 7.2%. Similar cost increases were projected for 2006.⁷⁵

An earlier experiment with a limited consumer-directed plan occurred in early 2001 when Humana Inc. responded to a projected 19.2% increase in claims costs by developing and testing a limited consumer-driven health plan on 4,800 employees in Louisville, Kentucky. As in the RAND experiment, a choice of plans was offered ranging from an HMO to an account that gave them a fixed amount to spend with a high deductible. Funds could only be spent on in-network providers for covered services and were not owned by the employee. The HMO policy cost employees \$36.36 per month, the \$5,000 deductible CoverageFirst plan cost \$10 a month.

As expected, healthier, higher income employees were early adopters of the high deductible plan. In the first year, the actual claims increase was 4.2% rather than the predicted 19.2%, an estimated \$2.1 million in savings. The savings came from three sources: additional employees moving into the high deductible plan, changes in benefits, and the fact that employees modified their behavior in response to plan incentives. In the first year, plan inpatient admissions fell by 14.4% while the broader Louisville market saw a 2% increase. Outpatient services were unchanged while the market saw an 8.2% increase. Employees had more physician office visits than the trend, 16.9 compared to 13.3 in the overall market, and used more prescription medications. Despite this, the company saved \$2.1 million in the first year. Employee out-of-pocket costs increased slightly, from 20.2% before the plan to 21.9% after.

Aetna has examined the short-term behavior of 49,000 employees enrolled in its health reimbursement account product. Costs increased at half the rate of those prevailing in traditional managed care plans. People enrolled in the Aetna HRA reduced emergency room visits, primary care provider office visits, and inpatient admissions. They increased specialist visits, an interesting fact given that proponents of cost control by utilization management have tried to limit specialist visits for decades. Enrollees with chronic conditions spent the same amount on maintenance medications or tests, had almost a 16% reduction in emergency room visits, and unchanged health status. In both the Aetna and Humana cases, insured individuals were more meticulous about using prescribed drugs.

A January 2006 census by America's Health Insurance Plans (AHIP) reported that about 3.2 million people were covered by HDHPs, triple the number a year earlier. Employer provided coverage went from 397,000 people in March 2005 to 1.4 million in January 2006. Buyers tend to be older, and roughly 30% were previously uninsured. Average annual family premiums for the best-selling HDHP policies in the large group market were \$6,385 with an average annual deductible of \$3,494 and an average annual out-of-pocket limit of \$6,385. Their premiums were considerably below the \$10,880 that the Kaiser Family Foundation Employer Health Benefits Survey quoted for traditional employer-sponsored family policies in 2005. In the market for individual HDHPs premiums were somewhat lower as one would expect given the medical underwriting that takes place, and deductibles were somewhat higher. Average annual deductibles for the best-selling product were \$4,760 with out-of-pocket limits of \$6,837. Average annual premiums for family policies aged 55 to 64 were \$5,690.⁷⁶

With the market for consumer-driven plans in its infancy, there is no reason to believe that either the current regulatory structures, or current plan offerings are automatically the best alternatives for reducing costs. In 1993, John Goodman and Discovery Health launched a consumer driven health plan in South Africa. It was based on the Medical Savings Account model. Competitors quickly copied the idea and today consumer-directed plans command about two-thirds of the private insurance markets. The most popular South African plans would not be allowed in the U.S. market. Under the assumption that patients typically have little control over inpatient care, there are no deductibles for it. Deductibles for outpatient care, over which patients typically exercise a great deal of discretion, are high.⁷⁷

Private arrangements abroad suggest that the structure of U.S. health insurance and even hospital health care would change substantially if consumers and producers were given more freedom to design their own health care arrangements. In Britain, for example, private hospitals routinely quote package prices on standard medical procedures that include consultant costs, drugs, devices, and any necessary treatment for unexpected complications. Patients with more involved conditions receive written offers, good for 30 days.

SUMMARY

Though a large fraction of health spending remains in private hands, the U.S. health care system has long been perhaps the most intensively regulated part of the U.S. economy, mostly with costly measures that have been loaded on since reformers began trying to remake the system in the 1970s. Christopher Conover of Duke University lists nearly fifty kinds of federal and state health services regulations including "regulation of health facilities, health professionals, health insurance, pharmaceuticals and medical devices and the medical tort system."⁷⁸

In 2002 the cost of health care regulation was roughly \$340 billion, about 20% of total health spending of \$1,560 billion. The calculated benefits from that regulation were \$212 billion, leaving a net cost of \$128 billion. If Conover is correct, merely repealing selected regulations, including those controlling hospital construction and ownership, those that limit experimentation in the form, content, and underwriting of health insurance, those that impose bloated educational requirements on health professionals, and those that limit innovation in drugs, devices, and new modalities of patient care has the potential to lower national health costs by roughly 10%.

As these experiments show, selective dismantling of the regulatory project offers great hope for the future. The Colorado experiment suggests that changes that make Medicare and Medicaid more like the food stamp program in replacing provider payments with cash accounts offer hope of significant cost savings and better care for patients. It also would allow responsible people on public assistance to purchase health care services in the same medical market that everyone else uses.

When coupled with health savings accounts, the switch to consumer-directed high deductible health policies from first dollar employer coverage may decrease current expenditures by 10% to 20%. It will also produce significant savings for old age costs at a time when the financial sustainability of the U.S. Medicare program is in doubt.

Because high deductible consumer policies are far less expensive, there is some evidence that they are being purchased by people without health insurance in the relatively lightly-regulated states that have healthy markets for individual health insurance.

Two clear choices face those who would shape future U.S. health care policy. Continuing to follow old habits of layered regulation, third party payment, and increasing government control will continue the current cost spiral and the recent deterioration in patient care. To protect a bankrupt Medicare program, government involvement will be extended into every nook and cranny of U.S. medical care. The regulatory overload will end private medicine and encourage those who can afford it to purchase their health care abroad.

The other choice is to deregulate, returning insurance to its traditional role as protecting against bankruptcy and promoting saving to pay for the higher health expenses that generally accompany old age. Let consumers spend their own money on health care, free of interference from professors with statistical studies and bureaucrats with specific notions of how people ought to behave. This is the choice that has the potential to stop the cost spiral, lower costs, and provide better health care for all Americans.

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Under the new federalism, government policy increasingly is made at the state and local levels. These public-policy decisions affect the life of every citizen in the state. Our goal is to provide nonpartisan research on key issues affecting Wisconsinites, so that their elected representatives can make informed decisions to improve the quality of life and future of the state.

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