POLICY BACKGROUNDER No. 136
For people with limited time and a need to know.

For Immediate Release
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Myths About Our Health Care System: Lessons for Policy Makers

Critics of the American health care system have propagated a number of myths to justify greater government control over our health care system. This backgrounder identifies 10 of the most common myths and exposes the fictions that underlie each.

Myth # 1: Life expectancy is a good indicator of health care quality. If you needed heart surgery, would you prefer to have the surgery done in Cuba, Barbados, Costa Rica or the United States?

Some people take life expectancy as a key indicator of the quality of a country's health care system. If they are right, you should be indifferent to whether your surgery is performed in Cuba or the United States, since the two have the same life expectancy, 75.6 years.[1] And you would have to conclude that the health care system of Barbados is nearly as good as that of the United States, since average life expectancy in Barbados (75.3 years) is almost the same.[2] In fact, if you took general life expectancy as your guide, you might choose Costa Rica, since life expectancy there (76 years) is higher than in the United States. [See Figure I.]

"Life expectancy is primarily a result of lifestyle, environment, education and other genetic and social factors."

Sounds silly? Of course it does. While a good health care system may extend the life of a small percentage of a population, the quality of health care people receive has only marginal impact on the average life span of the population as a whole. Life expectancy in all but the least-developed countries is primarily a result of lifestyle, environment, education and other genetic and social factors rather than the quality of medical care.

For example, Japan's average life expectancy (78.6 years)[3] is one of the highest in the world, about three years higher than that in the United States. If the three-year difference were the result of lower-quality U.S. care, Japanese-Americans living in this country should experience shortened life spans. They don't.

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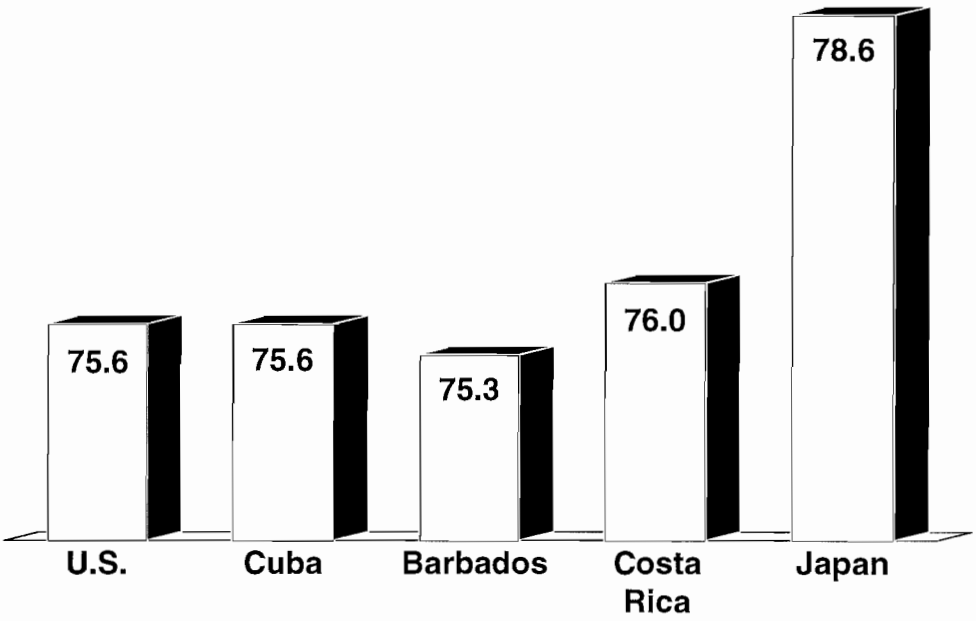
FIGURE I

Life Expectancy Among Countries

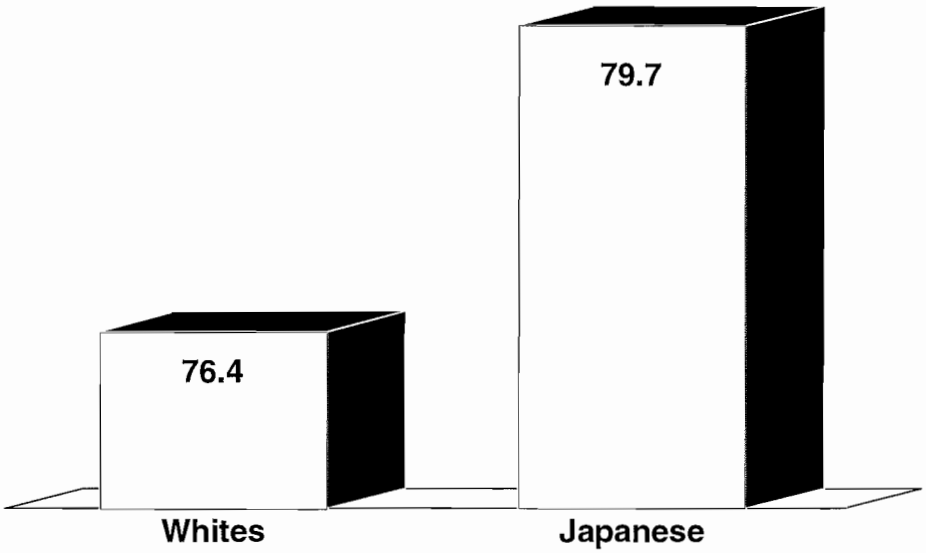
(In years, 1992)



Source: *Human Development Report 1994* (New York: Oxford University Press, 1994).

Life Expectancy in America

(In years, 1980)

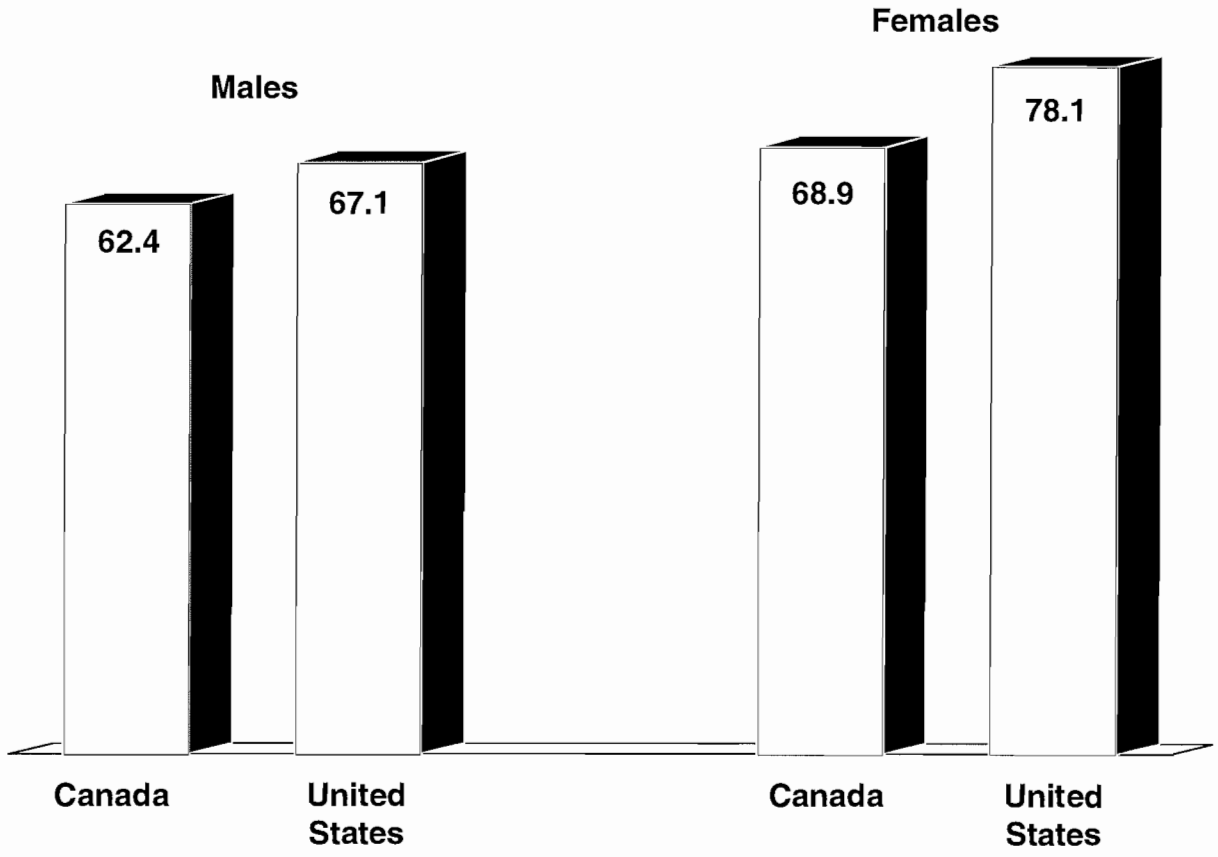


Source: R. W. Gardner, Bryant Robey and Peter C. Smith, "Asian-Americans: Growth, Change and Diversity," *Population Bulletin,* Vol. 40, No. 4, February 1989, p. 19. Figures are for the state of Hawaii.

"Life expectancy for Japanese-Americans is higher than for Japanese in Japan."

FIGURE II

Life Expectancy for North American Indians



Source: "Canadian Social Trends," Winter 1989, Statistics Canada. U.S. figures are from "Trends in Indian Health, 1991," U.S. Department of Health and Human Services.

- According to the National Asian Pacific Center on Aging, in 1980 (the latest comparison numbers available) white Americans had an average life expectancy of 76.4 years, while Japanese-Americans had an average life expectancy of 79.7 years — about the same three-year spread that exists between the populations of the two countries.[4]
- Similarly, the California Department of Health reports that people of Asian or Pacific Island ethnic origin living in the state have a life expectancy 5.3 years longer (81.2 vs. 75.9 years) than white Californians.[5]

"Most countries with higher life expectancies than the U.S. have overwhelmingly white populations."

Claiming that the American health care system is inferior to the health care systems of countries with longer life expectancies is like comparing apples and oranges. Nearly all of the industrialized countries with better life expectancies than the United States, except Japan, have overwhelmingly white

populations of European descent. None have large black populations. Unfortunately, black Americans have more health problems and shorter life expectancy (70 years in 1991) than whites. The American population is a mixture of ethnic groups — some with longer and some with shorter life spans than European whites.

When comparing ethnic groups across national borders, the U.S. statistics appear much more favorable. For example, life expectancy for male Indians in Canada is 62.4 years vs. 67.1 years for male American Indians. Among females the contrast is even greater, 68.9 years in Canada vs. 78.1 years in the United States.[6] [See Figure II.]

"Low infant mortality reflects differences in parental lifestyles, environment and genetic endowment rather than access to quality medical care."

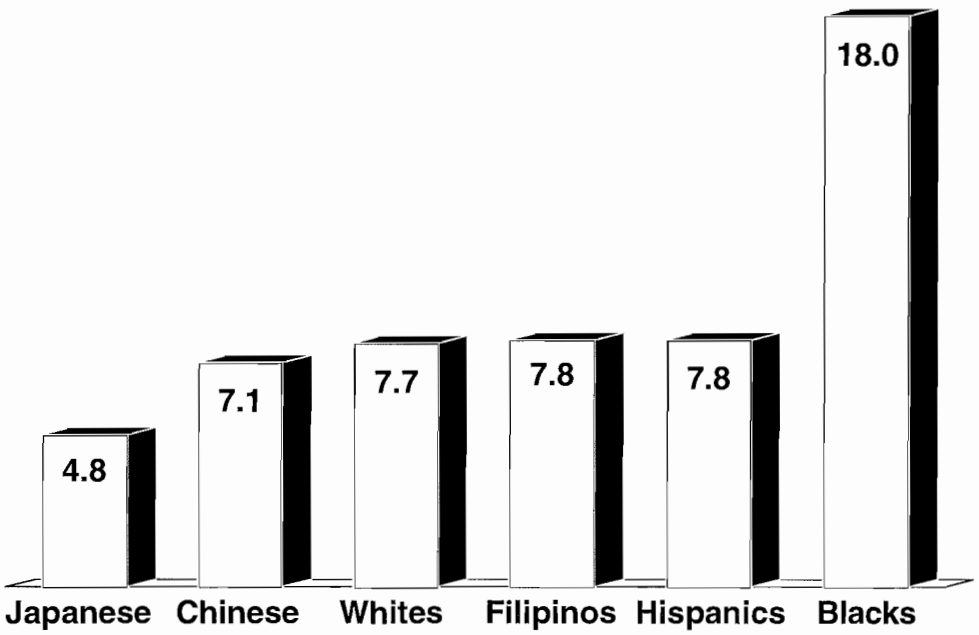
Myth # 2: Low infant mortality is a good indicator of quality. Some maintain that a low infant mortality rate indicates that a health care system provides easy access to prenatal care. However, the evidence shows that differences in infant mortality more frequently reflect differences in parental lifestyle, environment and genetic endowment than in access to quality medical care.

- Data from the California Department of Health Services, for example, show that the average infant mortality rate was 8.6 deaths per 1,000 live births in 1989.[7]

FIGURE III

Infant Mortality in California

(Deaths per 1,000 live births, 1982-1989)

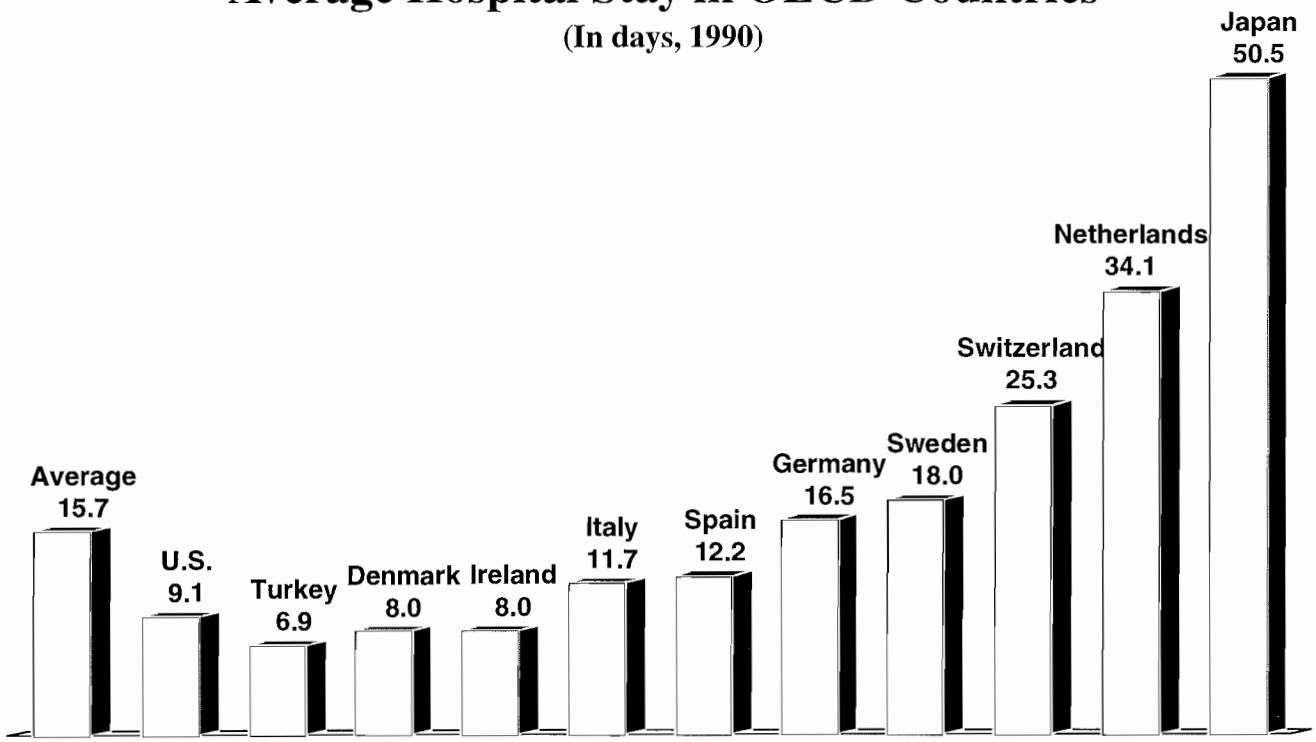


Source: State of California, Department of Health Services, Health Data and Statistics Branch, "Data Summary," November 1992.

FIGURE IV

Average Hospital Stay in OECD Countries

(In days, 1990)



Source: George J. Schieber, Jean-Pierre Poullier and Leslie M. Greenwald, "Health Spending, Delivery and Outcomes in OECD Countries," *Health Affairs*, Vol. 12, No. 2, Summer 1993, p. 126.

- But Americans of Japanese descent living in California had an infant mortality rate of 4.8 deaths per 1,000 live births in 1989 (the latest data available for this population).
- The Chinese had 7.1 deaths, Filipinos 7.8 deaths, Hispanics 7.8 deaths, whites 7.7 deaths and blacks 18.0 deaths per 1,000 live births.[8] [See Figure III.]

Since individuals in the different groups often live in the same communities and use the same hospitals and physicians, the differences in infant mortality rates cannot be attributed to the health care system.

"In 1990, the average U.S. hospital stay was only 9.1 days."

Critics of U.S. health care often claim that infant mortality rates among minorities would be lower if we had a single-payer system similar to that of Canada.[9] Yet in Canada the nationwide infant mortality rate is twice as high for Indians as for non-Indians, while the Indian infant mortality rate in the United States is slightly lower than that for non-Indians.[10]

Myth # 3: Time spent in hospitals is a good measure of the quality of care. Some also claim that more hospital admissions and longer stays indicate better care. By this standard, the United States rates poorly.

- The average hospital stay was only 9.1 days in the United States in 1990, compared to an average of 15.7 days in all developed countries.[11]
- In Japan, the average length of a hospital stay is 50 days, *more than eight times that of the United States.*
- As Figure IV demonstrates, only three OECD countries — Denmark (8.0), Ireland (8.0) and Turkey (6.9) — have shorter average stays than the U.S.

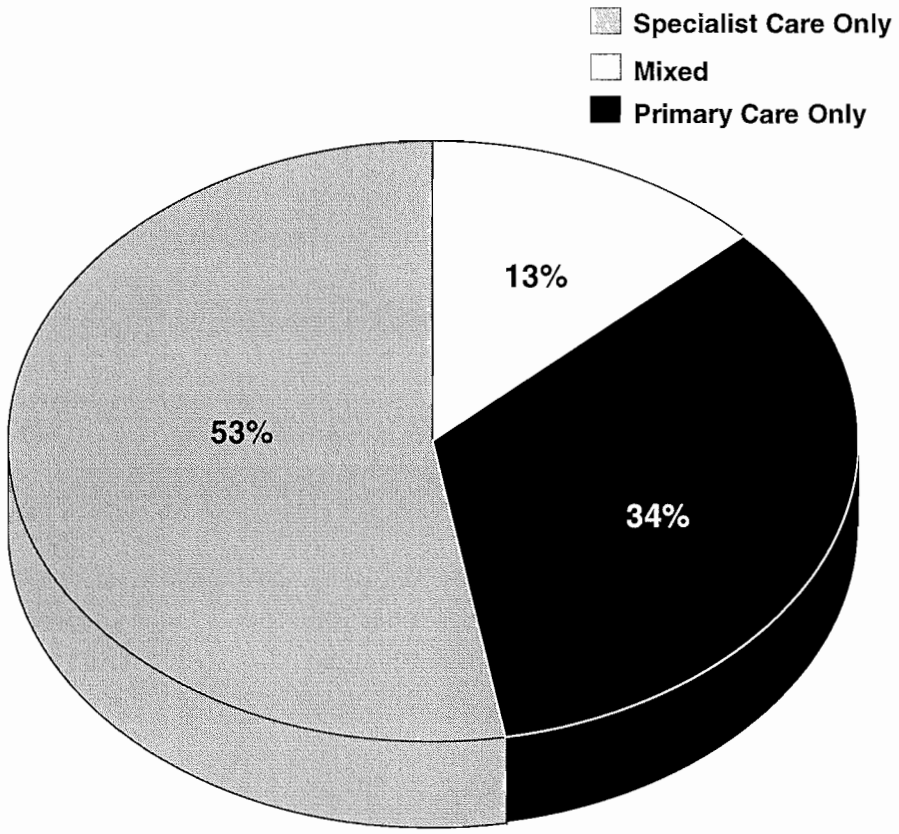
Far from being a problem, less inpatient and more outpatient care has been a *goal* of U.S. health care policy for the past two decades. And — other things equal — most health economists regard shorter stays as a sign of hospital efficiency, not of the failure to provide needed care.

Myth # 4: America has too many specialists and too few primary care physicians. Currently, about 70 percent of American medical school students choose specialties. The 1994 Clinton health care proposal would

"About 47 percent of all U.S. physicians engage in some form of primary care."

FIGURE V

Patient Care by Physicians



Source: Phillip R. Kletke, "Primary Care vs. Nonprimary Care Physicians: A False Dichotomy?" *Physician Marketplace Report*, American Medical Association, Center for Health Policy Research, April 1994.

have reduced that figure to 50 percent, forcing 20 percent of these young men and women into primary care practice.

But is there a shortage of primary care physicians? Not really. When was the last time you saw a waiting line outside a primary care clinic?

A recent survey by the American Medical Association found that if physicians who practice *both* specialized and primary medicine are combined with the 34 percent who practice primary care exclusively, about 47 percent of all physicians engage in some form of primary care — *nearly reaching Clinton's target with no government interference.*[12] [See Figure V.]

Primary care physicians are scarce in some rural and inner-city areas, but almost nowhere else. For example, a 1990 survey found that only 28 doctors serving a population of 1.7 million low-income people in New York's Harlem were qualified to provide primary care.[13] However, such a shortage has little to do with the percent of primary care physicians graduating from medical school and a lot to do with the lack of money spent to support such physicians in our inner cities and rural areas. Medicaid, the federal health insurance program for the poor, pays so little that very few physicians choose to locate in inner-city areas with a preponderance of Medicaid patients. And the population in some rural areas is not dense enough to support full-time physicians.

Myth # 5: Women need more access to prenatal care. The notion that free prenatal care would encourage more women to get care early in pregnancy, decreasing the number of problem pregnancies and births and ultimately saving money and lives, is not supported by the facts. Nonetheless, many recent health care reform proposals provided free prenatal care for all women, regardless of their financial status.

"Only 5.8 percent of all U.S. mothers wait until the last trimester or get no prenatal care at all."

According to the U.S. Department of Health and Human Services, only 5.8 percent of all U.S. mothers wait until the last trimester to get prenatal care or get none at all.[14] *Almost 94 percent of all mothers get prenatal care in the first two trimesters.*

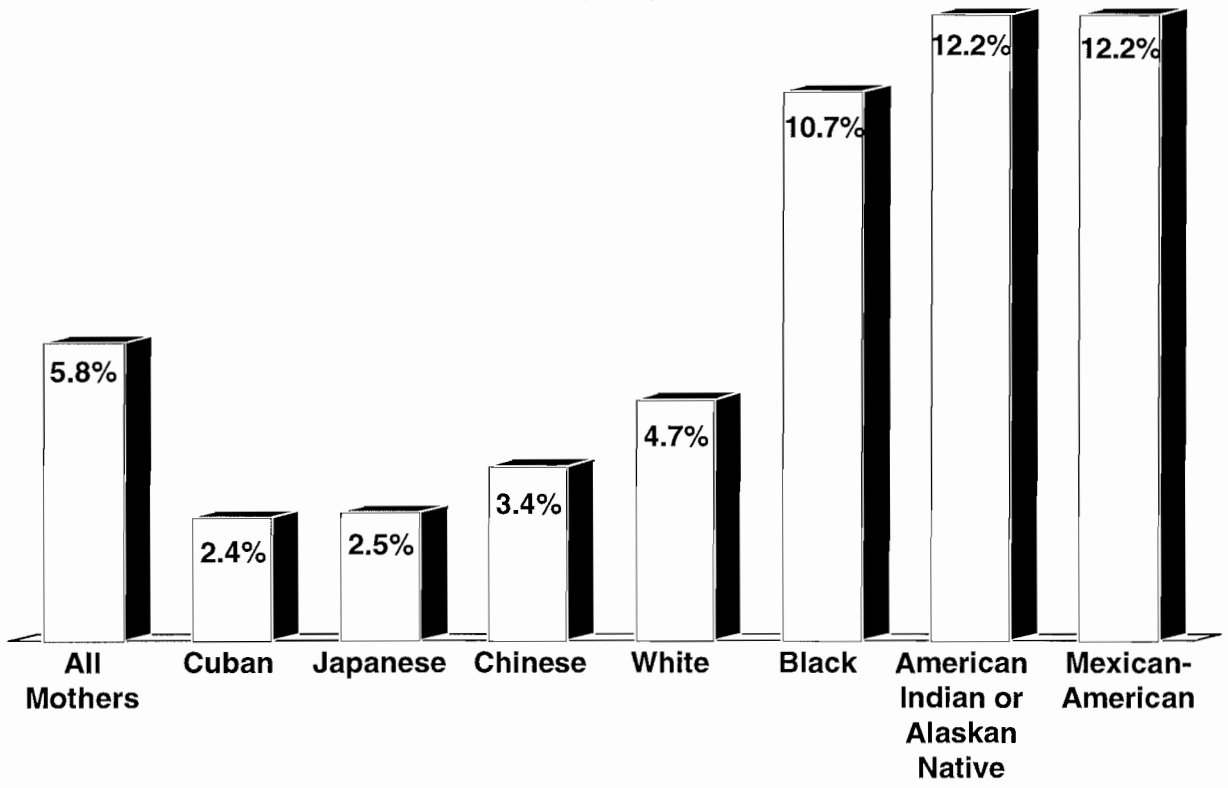
The incidence of prenatal care varies by racial and ethnic group:[15]

- Nearly 80 percent of white mothers get prenatal care in the first trimester, and only 4.7 percent wait until the third trimester or get none at all.
- The most frequent recipients of prenatal care in the first trimester are Japanese-Americans (87.7 percent) and Cuban-Americans (85.4 percent), and only 2 to 3 percent of either group waits until the third trimester. [See Figure VI.]
- By contrast, only 61.9 percent of black mothers and 58.7 percent of Mexican-American mothers see a doctor in the first trimester, while 10.7 and 12.2 percent, respectively, wait until the third trimester or get no prenatal care at all.

FIGURE VI

U.S. Women Getting Only 3rd Trimester or No Prenatal Care

(1991)



Source: "Health United States, 1993," U.S. Department of Health and Human Services, Table 9, p. 70. Figures are for 1991.

There is certainly room for improvement. But the fact that the vast majority of American women get prenatal care in the first trimester and that close to 100 percent of some populations get care in the first two trimesters should not be ignored.

"Nationally, more than 95 percent of children are immunized by the age of 5."

Myth #6: Preventive care saves money. A common complaint about our health care system is that people do not get enough preventive care, including prenatal care, immunizations, mammograms and physical checkups. Many argue that expanded preventive care would save health care dollars by preempting more costly acute care. For example, whereas prenatal care costs only a couple of hundred dollars, medical care for a premature baby usually costs nearly $20,000 more than a normal birth. And whereas vaccinations for measles, mumps and rubella cost about $20 each, the average hospital cost to treat those diseases is about $21,000.

On the theory that preventive care for all children and pregnant women would *save* money over time, many health care reform proposals include such services as free prenatal care, immunizations and well-baby care. But whether such proposals would expand access to care or save money is doubtful.[16]

Does free care increase access? Although nationally only a little more than half of all children are immunized by the age of two, more than 95 percent are fully immunized by age five so they can enter school.[17] Is the difference between the vaccination rate at ages two and five primarily due to the barrier of price? The evidence suggests otherwise.

Take Massachusetts, which has the nation's oldest free immunization program. Vaccinations there are available to all children without charge, regardless of the parent's financial means. Are all Massachusetts children immunized? Hardly.

- While the national average is about 58 percent of children properly immunized by the age of two, in Massachusetts the rate is 62 percent.[18] [See Figure VII.]
- In the 11 other states with free childhood immunization programs, the rates are only marginally better.[19]

Many contend that the cost of prenatal care is more than offset by a reduction in the number of premature and low birth weight babies, whose medical costs can be astronomical. Papers in scholarly journals have even specified savings from prenatal care. For every $1.00 spent, one paper said the savings would be $1.70, another said $2.57 and a third $3.38. However, a review of more than 100 such papers reveals:[20]

"With the oldest free child immunization in the country, Massachusetts immunizes only 4 percent more than the national average."

FIGURE VII

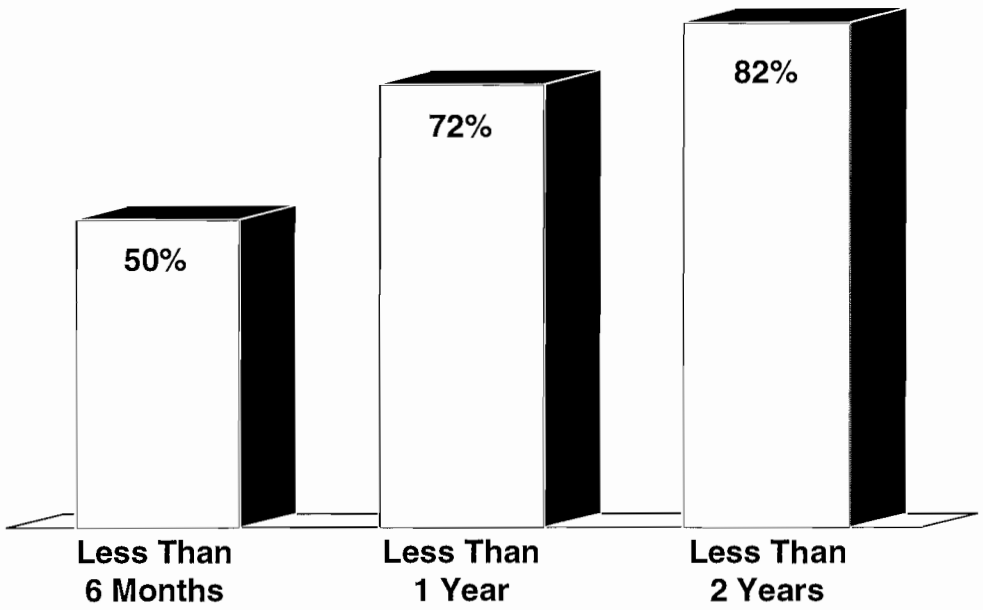
Do Free Immunizations* Improve Access?

* Full immunization (3 DTP, 3 polio and 1 MMR) by age 2.

Source: Rebecca Voelker, "Universal Vaccination Plan Gives Way to Compromise," *American Medical News,* May 24-31, 1993.

FIGURE VIII

How Long Do People Go Without Health Insurance?



Source: Katherine Swartz, "Counting Uninsured Americans: Background Memorandum," Kaiser Health Reform Project, Henry J. Kaiser Family Foundation, January 1994.

- Only a dozen papers made specific claims about the cost savings of prenatal care — and serious flaws in the methodology of all 12 made their findings questionable.
- Most of the other papers reviewed cited one or more of the 12 flawed papers as their proof that prenatal care pays for itself.

"Careful studies show that preventive medicine raises rather than lowers overall health care costs."

Careful studies show that, in general, preventive medicine raises rather than lowers overall health care costs. Although prenatal care is important, preventive medicine is "economical" only when special at-risk groups are targeted. Preventive services for the entire population usually cost more than they save.

This does not mean that preventive care is wasteful. Diagnostic tests often relieve patients' anxiety and reassure them of good health. Thus, for the most part, preventive care is like a consumer good that creates benefits in return for a cost. It is not like an investment good that delivers a positive rate of economic return.

Myth #7: Being uninsured is a chronic problem. The latest estimates suggest that at any one time 40 million Americans are uninsured.[21] And during the course of a year 58 million are uninsured for at least one month. However, most uninsured spells are temporary, half last less than six months and nearly three-fourths end within 12 months.[22] Ultimately, only 18 percent of all uninsured spells last for more than two years. [See Figure VIII.] Most

of the temporarily uninsured will, by definition, become insured eventually without changes in government policy. At the moment, the majority choose not to purchase private insurance because they judge its cost too high relative to its benefits. But many become insured after a change of jobs allows them to obtain insurance subsidized by employers and by government.

However, some individuals *are* chronically uninsured. Besides the long-term unemployed, they include drug dealers, prostitutes, others who work in the underground economy and people who are transient and homeless.

"Few people stay uninsured or unemployed for very long."

Being uninsured, then, is similar to being unemployed. The vast majority of people experience both conditions at some time in their lives, but very few stay uninsured or unemployed for long periods.

Myth #8: Preexisting conditions prevent a large number of people from obtaining health insurance. Sick people who lose their health insurance may find it impossible to purchase new coverage. Insurers may classify them as uninsurable, offer them a policy that excludes their preexisting conditions or set their risk-rated premiums unaffordably high.

How big is this problem? Not very big. According to the Agency for Health Care Policy and Research, a branch of the U.S. Public Health Service, only 0.7 percent of the U.S. population (about 2 million people) has been denied health insurance due to a medical condition.[23] And while we do not know how many people pay excessive health insurance premiums, it cannot be very many. Only about 3 percent of the population say they are in fair or poor health.[24]

One solution for those with preexisting conditions is the establishment of state-based risk pools. Currently, 28 states have passed legislation creating high-risk pools that sell health insurance to approximately 100,000 individuals with preexisting conditions.[25] [See Figure IX.] In most states, the premium for risk pool insurance is between 25 and 50 percent higher than for comparable policies a healthy person can buy, though some states can require people to pay more if the program's losses warrant it.

To join a risk pool in most states, individuals must prove that at least one of the state's insurers has rejected them. To discourage people from waiting until they are sick to get insurance, most of the pools can impose a preexisting condition exclusion period.

The biggest problem with risk pools is underfunding. Texas, an extreme case, has had a risk pool on the books since 1989 but has never funded it. At least one state excludes certain medical conditions from coverage. And some states exclude people from coverage if they have reached the lifetime benefit provided by the plan.

"High-risk pools enable anyone with a medical condition to get insurance."

Risk pools enable anyone with a medical condition to get insurance, and the amount of money needed to fully fund state risk pools is almost trivial in the context of a one trillion dollar health care system. In 1992, for example, risk pool subsidies nationwide totaled only $170 million. One study found that extending risk pool insurance nationwide would have cost only $300 million in 1989, out of a national health care bill of $604 billion that year.[26] The study concluded that aggressive cost control techniques could significantly reduce that expenditure. But even without cost control, risk pool insurance problems could be solved for less than one-tenth of one percent of the nation's annual health care bill.

Myth #9: The uninsured are freeloaders. Many Americans without health insurance are "freeloaders," said Hillary Rodham Clinton.[27] When they get health care, they often stick the rest of us with their bills, which we pay through higher taxes and higher insurance premiums. It's in our self-interest, she said, to force them and their employers to buy health insurance.

Mrs. Clinton conceded that the uninsured *are not* denied health care when they need it, despite that assertion by others promoting health care reform. Using 1987 data, the Agency for Health Care Policy and Research found that the uninsured received 108 percent as much care as the insured ($5,270/insured person vs. $5,679/ uninsured) while in the hospital.[28] Overall, the study found that the uninsured spent 70 percent of what insured people spent ($1,305/insured person vs. $919/uninsured).[29]

FIGURE IX

Distribution of High-Risk Pools

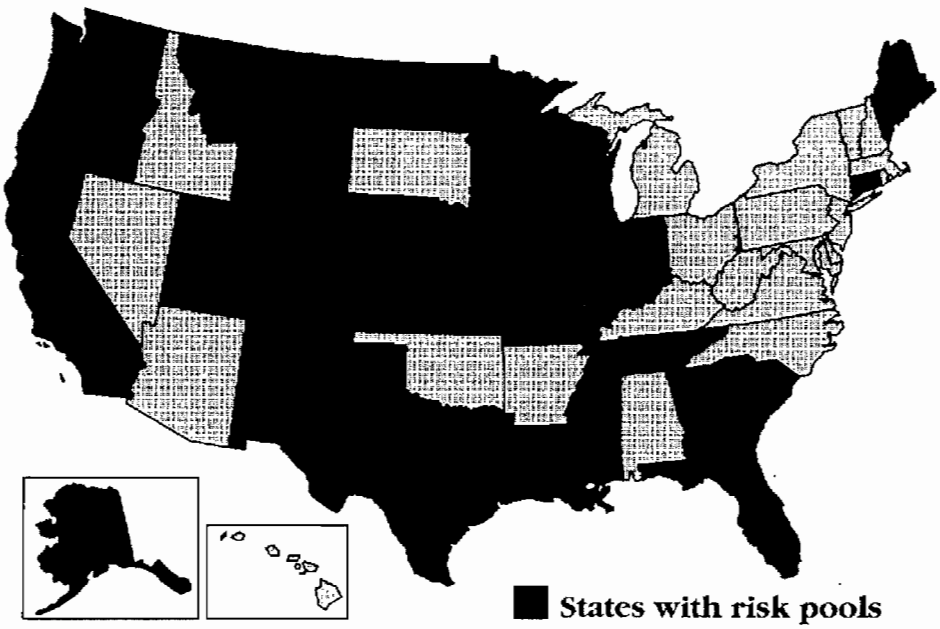
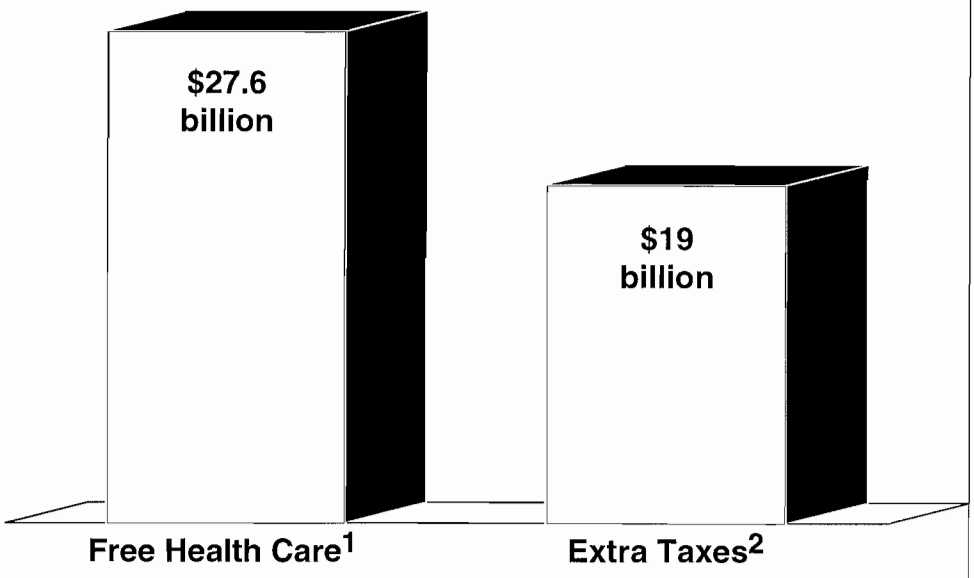


FIGURE X

Benefits and Costs of Being Uninsured



[1] 1995 estimate based on Congressional Budget Office estimate for 1991.

[2] National Center for Policy Analysis/Fiscal Associates estimates for 1995.

"The CBO estimates that in 1991 the uninsured caused $20.3 billion in costs to be shifted to paying patients."

But the uninsured pay directly for only a portion of their care. The Congressional Budget Office (CBO) has estimated that they pay about 30 percent each year. As a result, the CBO estimated that in 1991 the uninsured received about $15.2 billion in "uncompensated" hospital care and another $10.2 billion in "uncompensated" physician services.[30] After making some adjustments, the CBO estimated that in 1991 the uninsured caused $20.3 billion in costs to be shifted to paying patients.[31] Then the CBO predicted that the figure would grow to $27.6 billion by 1995, costing us about $1,645 per uninsured household. [See Figure X.]

But while they are getting some free health care, the uninsured are penalized through higher taxes. They do not receive the tax subsidies enjoyed by those who have employer-provided health insurance.

Taking part of their income as a health insurance fringe benefit, many middle-income employees escape a 28 percent income tax, a 15.3 percent FICA (Social Security) tax and a 4, 5 or 6 percent state and local income tax on that money. The value of this tax subsidy equals as much as half of the cost of health insurance. Altogether, the federal government "spends" about $86 billion a year in tax subsidies for health insurance, and state and local governments spend another $10 billion.[32] These subsidies are not, however, enjoyed by people who receive all of their income as wages and have no fringe benefits.

The opposite of a tax subsidy is a tax penalty. When government offers tax subsidies to people conditional on their purchase of health insurance, those who do not purchase it pay higher taxes. The higher taxes may be thought of as a penalty for being uninsured.

"Uninsured families pay about $1,018 more in taxes each year because they lack employer-provided insurance."

Using the National Center for Policy Analysis/Fiscal Associates Health Care Model, Gary Robbins and Aldona Robbins found that, on the average, uninsured families pay about $1,018 more in federal taxes each year because they do not have employer-provided insurance.

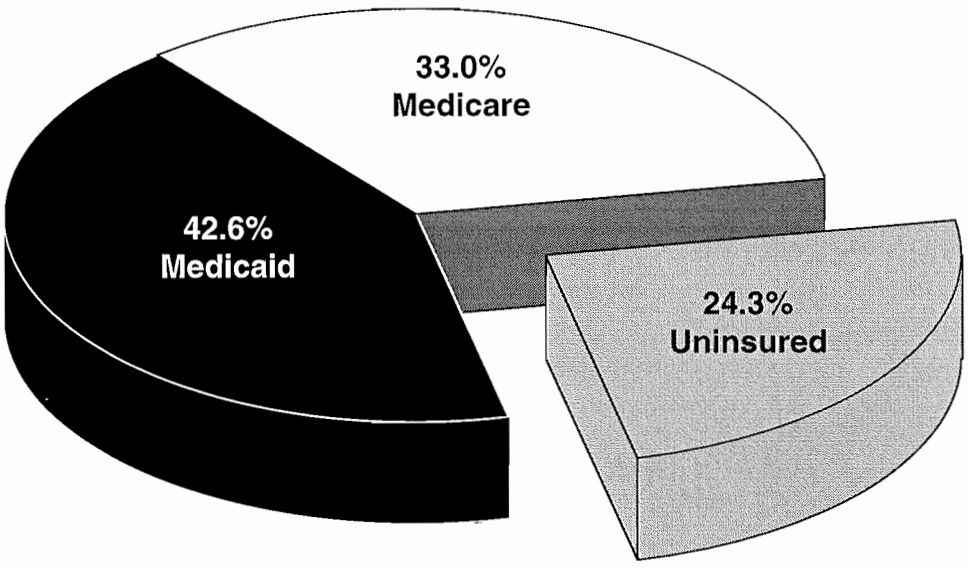
- Collectively, the uninsured pay about $17.1 billion in extra taxes each year because they do not receive the same tax break as insured people with similar incomes.
- If state and local taxes are included, the uninsured pay more than $19 billion in extra taxes each year.
- Far from freeloading, the uninsured are paying a penalty equal to more than two-thirds of the value of the uncompensated care they receive each year.

In fact, given the uncertainty about the amount of uncompensated care provided, uninsured people are arguably paying their own way.[33]

FIGURE XI

Sources of Uncompensated Health Care

(1995)



Source: Projection by Gary Robbins and Aldona Robbins of Fiscal Associates based on Sandra Christensen, *CBO Staff Memorandum: Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates* (Washington, DC: Congressional Budget Office, April 1993), Table 7, p. 25.

Myth #10: Health reform can be financed by eliminating waste from federal programs. In the 103rd Congress, the Clinton administration and several Republicans proposed to fund health care reform by cutting funds for Medicare and Medicaid. The original Clinton health care plan cut Medicare and Medicaid spending by $104 billion over the next five years. And many in the 104th Congress are considering similar cuts. Such a proposal would increase health care cost shifting from the public to the private sector.

According to the CBO, Medicare and Medicaid payments to hospitals are 70.3 percent and 62.5 percent of private patient payments, respectively.[34] Medicare and Medicaid payments to physicians are 70 percent and 45 percent of private payments, respectively.[35] As Figure XI shows, the biggest sources of uncompensated care in our health care system are Medicare (33.0 percent) and Medicaid (42.6 percent). When the government undercompensates for medical services, providers shift those costs to patients with private health insurance, forcing their premiums to rise.

"The CBO estimates that Medicare and Medicaid are the biggest sources of uncompensated care in the health care system."

Lawmakers need to realize that they cannot eliminate waste by shifting costs. The only rational way to eliminate waste is to give consumers a financial stake in their decisions. Until Congress creates a system in which Medicare and Medicaid recipients benefit from prudent health care consumption (for example, through Medical Savings Accounts), waste and overconsumption will continue.

Conclusion

If we are going to solve America's health care problems, we need to understand them. Otherwise, we will be throwing money and programs at problems that really do not exist. But understanding our health care problems means eliminating some of the myths that surround the health care debate. Reforms targeted at vulnerable populations will do a better job than huge bureaucratic programs of getting care to those in need.

Merrill Matthews, Jr.
John C. Goodman

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

[1] United Nations Development Programme, "Human Development Report 1994" (New York: Oxford University Press, 1994), pp. 129-30.

[2] Ibid.

[3] Ibid.

[4] R.W. Gardner, Bryant Robey and Peter C. Smith, "Asian Americans: Growth, Change and Diversity," *Population Bulletin,* Vol. 40, No. 4, February 1989, p. 19. Figures are for the state of Hawaii.

[5] Charles M. Chan and Anthony Oreglia, "California Life Expectancy: Abridged Life Tables for California and Los Angeles County, 1989-91," Health and Welfare Agency, California Department of Health and Human Services, August 1993, p. 24.

[6] "Canadian Social Trends," Winter 1989, Statistics Canada. U.S. figures are from "Trends in Indian Health, 1991," U.S. Department of Health and Human Services.

[7] "Infant Death Rates by Race/Ethnicity, California Birth Cohorts, 1982-89," *Data Summary*, California Department of Health Services, Health Data and Statistics Branch, November 1992.

[8] Ibid.

[9] A new study by the *Journal of the American Medical Association* comparing birth weight and perinatal mortality found that the higher level of perinatal mortality in the U.S. is due almost entirely to the higher percentage of low-weight, preterm births (2.9 percent of U.S. births vs. 2.1 percent in Norway). According to the report, the survival of newborns at any given weight (i.e., when they are in the health care system) is "virtually the same in the United States and Norway." Allen Wilcox et al., "Birth Weight and Perinatal Mortality: A Comparison of the United Sates and Norway," *Journal of the American Medical Association*, Vol. 273, No. 9, March 1, 1995, pp. 709-11.

[10] Jean-Pierre Thorrez, Peter Foggin and Andre Rannou, "Correlates of Health Care Use: Inuit and Cree of Northern Quebec," *Social Science and Medicine*, Vol. 30, No. 1, pp. 25-34.

[11] George J. Schieber, Jean-Pierre Poullier and Leslie M. Greenwald, "Health Spending, Delivery and Outcomes in OECD Countries," *Health Affairs*, Vol. 12, No. 2, Summer 1993, p. 126.

[12] Phillip R. Kletke, "Primary Care vs. Nonprimary Care Physicians: A False Dichotomy?" *Physician Marketplace Report*, American Medical Association, Center for Health Policy Research, April 1994.

[13] Elisabeth Rosenthal, "Doctor Deficit in Poor Urban Areas Is Seen as Barrier to any Health Plan," *New York Times*, October 18, 1993.

[14] "Health United States, 1993," U.S. Department of Health and Human Services, Table 9, p. 70. Figures are for 1991.

[15] Ibid.

[16] See Louise B. Russell, "The Role of Prevention in Health Reform," *New England Journal of Medicine*, Vol. 329, No. 5, July 29, 1993, pp. 352-54. For a more extensive examination, see Louise B. Russell, *Is Prevention Better Than Cure?* (Washington, DC: Brookings Institution, 1986). See also Kevin Fiscell, "Does Prenatal Care Improve Birth Outcomes? A Critical Review," *Obstetrics and Gynecology,* March 1995.

[17] "White Paper: Merck Vaccine Division Principles and Immunization Enhancement Initiatives," Merck and Co., Inc. (no date). See also Mona Charen, "Do We Need A Federal Pharmacist?" *Washington Times*, February 18, 1993.

[18] Rebecca Voelker, "Universal Vaccination Plan Gives Way to Compromise," *American Medical News,* May 24-31, 1993.

[19] Ibid.

[20] Jane Huntington and Frederick A. Connell, "For Every Dollar Spent — The Cost-Savings Argument for Prenatal Care," *New England Journal of Medicine*, Vol. 331, No. 19, November 10, 1994.

[21] "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey," Employee Benefit Research Institute, EBRI Special Report and Issue Brief No. 158, February 1995.

[22] Katherine Swartz, "Counting Uninsured Americans: Background Memorandum," Kaiser Health Reform Project, Henry J. Kaiser Family Foundation, January 1994.

[23] Karen M. Beauregard, "Persons Denied Private Health Insurance Due to Poor Health," Agency for Health Care Policy and Research, U.S. Public Health Service, AHCPR Report No. 92-0016, December 1991.

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