PART I

INTRODUCTION

1. America's Health Care Crisis

America's health care system is in crisis. That's the conclusion of virtually every commentator on American medicine, regardless of political persuasion. Ask any doctor, any patient, any business executive or politician. Indeed, virtually everyone who has even remote contact with health care agrees that the system is in serious need of reform.

The crisis is not new. It has been emerging for at least two decades. Over that period, an almost unlimited number of recommendations for reform have been made. Yet we are no closer to solving the crisis today than we were 20 years ago.

One reason there is no consensus on the solution is that there is no agreement on the problem. What each of us believes the nature of the crisis to be depends on where we stand in relation to the health care system.

Why We Can't Agree on the Nature of the Crisis

For employers and many public officials, the crisis is one of costs. America, they remind us, is spending more than $800 billion a year on health care—about $3,200 per year for every man, woman, and child. Health care spending is approaching 13 percent of our gross national product, more than in any other country in the world.

Yet for every cry of alarm over rising health care spending, there are at least two or three cries over our failure to spend more. Some 34 million Americans, we are told, lack health insurance. The policies of many who do have health insurance exclude mental health care or treatment for alcohol and drug abuse. Then there is a seemingly endless list of unmet health care needs: prenatal care for the young, nursing home care for the old, organ transplants, and underfunded medical research. The most popular measures before Congress and the state legislatures are proposals not to lower health care spending but to extend health insurance to more people and more services.

The conflict of perspectives does not end there. For example, to most doctors the main problem is bureaucratic interference from government, insurers, employers, and even hospital administrators—interference that raises costs and sometimes lowers the quality of patient care. But to almost all third-party (insurance) payers and many hospital administrators, the problem is that doctors have too much freedom—especially to increase prices. Almost every patient who sees a hospital bill believes the hospital overcharges. Almost all employers and insurance companies share that view. But almost all hospital administrators believe their hospitals are undercompensated and worry about what services they will cut if they do not somehow increase revenues. Many physicians have a similar view. Before examining this list of conflicting perspectives, it is worthwhile to consider how they develop.

A Trip through the Health Care System with the Adams Family

The people in the following vignettes are fictitious. The kinds of events described are real, however, and occur all too frequently.

Jeff Adams (Patient)

Jeff Adams was furious. He had been out of the hospital for more than a month, but "$3,296.24" was indelibly stamped in his mind. That was the bill for minor surgery and a few days' stay in a hospital run by his own brother! He tried to see the other side of things. That was what his wife, June, kept telling him to do. Sure, hospital costs were up—hospitals could do a lot more things these days. And his share of the bill was less than $800. Blue Cross would pay the rest, or at least that was what he initially thought. Still, it was the principle of the thing.

He had gone to see his brother about the bill. "Bob," he had said, "there's got to be some mistake here. Fifteen dollars for one Tylenol tablet? You've got to be kidding. Had I known that, I would have gotten out of my sickbed, walked across the street, and bought my own Tylenol." It was Bob's attitude that bothered him more than anything else. Bob wouldn't even back down on the price of the hospital admission kit, which had contained personal items such as a toothbrush, comb, and small razor. "Twenty-five dollars for a little kit, just like the ones airlines give you for free on international flights? C'mon, Bob, that's ridiculous," he had said.

"Maybe it would have ended there, with me blowing off some steam," Jeff thought. "But hell, I'm a businessman. I see these damn insurance premiums going up year after year, and no wonder—$15 for a Tylenol tablet?" That's why he'd gone to Blue Cross. He'd felt a little guilty, pointing a big insurance company toward his brother. Still, Blue Cross was paying 80 percent of the bill. And somebody has to do something about these health care costs, don't they?

Things hadn't worked out in quite the way he'd expected. Oh, they had been pleasant enough at Blue Cross. The woman had listened carefully. She'd promised to look into the matter. But somehow Jeff had known at the time that nothing was going to change.

He'd almost gotten over the whole thing. Until last night when June had invited Bob over for dinner. It was supposed to be the time for reconciliation. "And I certainly tried to be nice," Jeff thought. The trouble had started when Bob made that comment about the hospital's charges.

"Look at it this way, Jeff," Bob had said. "You paid less than $800 for three days in the hospital. That's about what you'd pay to stay in a nice hotel without any medical care at all. That's cheap."

"Sure, that made me angry," Jeff thought. "But I controlled it. Without even raising my voice, I patiently explained to Bob how health insurance premiums work. June was probably right. I probably was patronizing. Maybe that's why Bob got personal."

"Jeff, you and I both know that you took advantage of your health insurance, just like everybody else does," Bob had said. "Your doctor told you that the surgery could be done as an outpatient. But you both agreed you'd check into the hospital and rest for a couple of days because your health insurance would pick up most of the tab. You and June thought that was a great idea."

That had made him even angrier, Jeff remembered. But he'd controlled himself. In fact, he'd controlled his emotions all evening—until Bob brought up that stuff about Blue Cross.

Bob Adams (Jeff's Brother, Hospital Administrator)

Bob Adams was feeling unsettled. He never should have told Jeff about the deal with Blue Cross. He'd known it was a mistake the minute he'd said it. "Jeff," he'd said, "we have a special deal with Blue Cross. They paid a flat rate of $640 for each day you were in the hospital. They couldn't care less what was on your hospital bill." That was when Jeff hit the roof.

Irene did have lung cancer, and by the time Kay discovered it, it was too late—six months later she was dead. "It was the most traumatic thing I've ever been through," Kay thought. Talking to her friend Jack, an oncologist, helped a lot. "Kay, it's not your fault," Jack had said. "In my field, Medicare kills people all the time. The government won't pay for the best drugs, so we treat cancer patients with inferior drugs. If I took personal responsibility for every preventable death, I'd have to check into a mental institution."

"People need to know about these things," Kay had told Jack.

"Yeah, but unless you want a malpractice suit, you're not the one to tell them," Jack had said.

Kay thought about that. Then she remembered another problem she'd heard about at the hospital that day—the problem involving Jeff Adams's father.

Mark Adams (Jeff's Cousin, Pacemaker Manufacturer)

Mark Adams was angry. What had he spent his whole adult life doing? Nothing less than making the best pacemakers in the whole world. And what did his cousin, Jeff, do when his own father needed a pacemaker? Totally ignored every damn thing he told him!

The incident began over a year ago, when Jeff's father George was diagnosed as having a heart problem. But Mark found out just this morning what had ultimately happened. He vividly remembered his conversation with Jeff when the issue first came up. "Jeff," he had said, "I make pacemakers. Now I can sell you an old-fashioned one, or I can sell you a really good one. The government won't pay for the good ones. But your father's still employed. That means he's covered by private insurance, not by Medicare. I'll tell you what kind of pacemaker to get, and you make sure George gets it."

Mark had assumed it had all been taken care of. Until this morning, that is. Mark was talking to George on the phone when he casually asked what kind of pacemaker George had. It was the wrong kind. Not wanting to alarm George, he controlled his anger and got off the phone as quickly as possible. He showed no such restraint when he got George's doctor on the phone. Before the doctor could hang up on him, Mark learned that George's private

insurance carrier had adopted the same policy as Medicare. They refused to pay for higher quality pacemakers.

Mark had always thought that government was the greatest single threat to Western civilization. But it was increasingly clear to him that insurance companies were in second place and closing fast. The only thought that comforted him was his decision to end his company's employee health insurance plan. "What more evidence," he thought, "does anyone need to see the correctness of that decision?"

About three months earlier, Mark had met with his accountant. "We're a small company competing with Williams, Inc., a giant multinational," Mark had said. "The only way we can compete is to keep our costs down. So let's make sure our health insurance costs are below theirs."

"Can't be done, Mark," his accountant had said. "Why not?" Mark had asked. "Because Williams has a no-frills, bare-bones policy. Your policy covers acupuncture, in vitro fertilization, alcohol and drug abuse treatment, chiropractic services, and lots of other extras."

"Then get rid of the frills," said Mark, without thinking twice about it. "Can't," said the accountant. "Why not?" asked Mark. "State law," the accountant said. "Well, how the hell does Williams get around all that?" asked Mark. "Williams is a large company," he was told. "Federal law allows large companies to escape state regulation. Small companies can't escape."

That's when Mark decided he'd had it with health insurance. For the past two years his company had faced premium increases of 30 percent per year. "At that rate, we'll be bankrupt in five years," Mark had told his employees. To compensate, Mark gave every employee a $750 bonus to buy their own health insurance if they wanted it.

"But Mark," his accountant had said, "you've got to take taxes out of that $750. And lots of employees will just spend the remainder on other things. You're going to have a lot of people around here without any health insurance."

Privately, that thought bothered Mark. But it bothered him even more that Williams, Inc., had a way out of this problem, and he didn't. "There's government again," he thought, "sticking it to the little guy. And what am I supposed to do about it? It's better for the employees to be without health insurance than without jobs."

Then Mark remembered that his sister worked for a U.S. senator who was very involved in health care issues. He decided to give her a call.

Nancy Adams (Mark's Sister, Aide to a U.S. Senator)

Nancy Adams was troubled. She had just talked by phone with her brother Mark. What Mark had said bothered her. But what bothered her even more was the conversation she'd had with Senator Blake the day before.

She'd worked for the senator for two years. Since Blake was the most important person in Congress on health care issues, she'd received many telephone calls in those two years from people all over the country—people just like Mark, but with far more serious problems. In most cases, the senator gave her brief instructions on how to handle the problem (send a letter to this person, place a call to that person, etc.). But yesterday the senator had really talked with her.

He had just come back from an important meeting. She'd never seen him so depressed. He'd sat down and started talking. "Nancy," he'd said, "let me tell you how health care works in this country. If we did everything doctors know how to do to help people, we would spend our entire gross national product on health care. Nobody but a lunatic would suggest that. So what we do is say to the medical community, 'This is all the money you get; you figure out how to spend it.'"

"We don't put any restrictions on how they spend it?" Nancy had asked.

"Restrictions?" Blake had responded. "Of course we've got restrictions. Thousands of them. Medical care in this country is an $800 billion-a-year industry and every interest group is here in Washington trying to get a slice of it. We've got so many special-interest rules that I don't know how the hospitals keep track of them."

Blake had leaned back in his chair, becoming more reflective. "Nancy, we can pass laws all day and all night, and it's not going to matter whether the hospitals obey them or break them." Blake had paused for a moment. Then he'd said, "The bottom line is this. If you don't have money, you can't give care. The squeeze is on. And if the hospitals think they're being squeezed now, they have no idea how bad it's going to get."

"But why can't you just explain to people what the problems are?" Nancy had asked.

"Because nobody dares," Blake had retorted. "You can't talk authoritatively about something unless you know about it. You can't know about it unless you've participated in the decisions. And if you've been involved in the decisions, then you're personally responsible for causing people a lot of harm. If I admitted what I do here in Washington, I'd never get reelected. If hospital administrators or physicians admitted what they are doing, they'd be sued for malpractice."

"But what do people in other countries do?" Nancy had asked.

"It's worse. In Britain, doctors probably spend more time denying people care than giving it."

Nancy had been baffled. The longer she worked for the senator, the more convinced she was that the health care system had problems. Now she had heard from the horse's mouth that the problems were worse than she had ever imagined.

"So what can we do?" she had blurted.

"What I'm going to do is stay here a few more years, collect a nice pension and leave Washington for good," Blake had said. "As for the health care system, I don't know what you can do. I don't know what anybody can do."

Senator Blake had gotten up slowly and left the room. He never discussed health care with Nancy again.

How This Book Differs from Other Books on Health Policy

In the brief account of the Adams family, we met people who had interacted with the health care system—from patient to physician, hospital administrator to equipment manufacturer, employer to politician. In each vignette there were also unseen actors whose behavior was vitally important. Even though we examined only a few episodes, the problems we encountered were wide-ranging—from how government should spend its health care dollars to how hospitals, insurance companies, employers, and even patients make important decisions. In some cases, it was clear that too much was being spent and resources were being wasted. In other cases, too little was being spent, sometimes at the cost of human life.

and vice versa. In such an environment, when others pursue their interests, you and I are often made worse off.

Quite a different result emerges in competitive markets with clearly defined private property rights and individual freedom of choice. In this environment, you and I cannot pursue our own interests (for the most part) without creating benefits for others. Conversely, others rarely can pursue their interests without creating benefits for us.

Health Care Delivery as It Can and Should Be

Consider how differently the Adams family would have fared in a world in which the medical marketplace works at least as well as the market for other complex services, and the market for health insurance works at least as well as the market for other kinds of insurance.

Jeff Adams's Surgery

If the medical marketplace worked the way other markets do, Jeff Adams would pay for his surgery with his own money. It might be money he had saved or money he had received from his health insurer once his condition had been diagnosed. But the money would belong to Jeff Adams and he—not some remote bureaucracy—would be the principal buyer. In all probability, Jeff would choose outpatient surgery, the less expensive option. But if he chose inpatient surgery, the hospital would behave quite differently from the way hospitals operate today.

Before admitting Jeff, the hospital probably would give him a single package price covering all services. He could then compare it to the prices of competing hospitals. Few hospitals would refuse to state their prices in advance or present unreadable statements at the time of discharge. Hospitals that did those things would have mostly empty beds.[3]

June Adams's Headaches

If the health insurance market worked the way other insurance markets work, it is highly unlikely that June Adams would receive any insurance money for headaches.

[3]Some hospitals might quote an estimate or a range, or give an average with a not-to-exceed maximum. We would also expect some variety in pricing schemes.

Health insurance would be restricted to rare, unusual events that have very costly consequences.[4] Because using health insurance to pay small medical bills for routine services is costly and wasteful, June Adams would use her own money to pay for most physicians' visits and diagnostic tests. If June's insurer did pay her some money for headaches, it would be hers to spend as she chose. Given her initial reaction to her doctor's questions, it is unlikely that she would pay for an MRI scan. If she did, she certainly would not check into a hospital.

George Adams's Pacemaker

As in the cases of Jeff and June Adams, George Adams would be purchasing a pacemaker with his own money. A large part of what he spent would come from the insurance check he received once his heart problem was diagnosed. But he might also have to use some of his savings.

Because George, not an insurance company, would be the customer, pacemaker manufacturers would seek him out. Higher quality pacemakers would still cost more, so George would have to evaluate the risks and the costs. Certainly he would consult his physician. But because the insurance company would no longer be the principal client, his doctor's advice would be far more informative and complete.

Irene Adams's X-ray

If Medicare insurance worked the way most other insurance works, Medicare would be irrelevant in Irene's life unless she were diagnosed with a major illness. At that point she would receive a check. In the meantime, Medicare would not care whether Irene coughed or didn't cough, and her doctor would have no forms on which to report such trivia.

Her doctor would be in the business of selling services, and if Irene chose to purchase chest x-rays, she would be spending her own money. Because Irene, not Medicare, would be the customer, her doctor would have an incentive to encourage her to have an annual chest x-ray, especially in view of her smoking history. Irene

[4]Reimbursement would probably be limited to severe cases in which the individual is diagnosed as needing treatment by a specialized professional.

could also solicit advice from other physicians. In all probability, x-ray machine manufacturers would advertise directly to people such as Irene—since Medicare would no longer be their client either.

Odds are that Irene would receive encouragement from many sources to get the annual x-ray. The choice would be hers.

Mr. Hansen's Hospital Admission

If the medical marketplace functioned as other markets do, when Mr. Hansen got to the emergency room he, not Medicare, would be the hospital's potential customer. If he entered the hospital, he would be spending his own money, although Medicare might already have paid a claim to him for his condition.

The Hansen family may not have much money. But Hansen was not on Medicaid, so he probably was not living in poverty. Hansen and his family might have been a hard sell. But a hospital in a competitive medical marketplace would be in the business of selling services to people, not insurers, and in the Hansen case the argument for immediate hospitalization would be very persuasive. At the very minimum, the Hansen family would make an informed choice.

Group Insurance for Mark Adams's Employees

If the health insurance market were freely competitive (or at least as free of regulatory obstacles as the market for life, fire, and casualty insurance), state legislators would not tell Mark Adams's company what to include in the company's group health insurance plan. Mark and his employees would simply agree on an affordable package of benefits. The employees might have to forgo some frills, but they would still have catastrophic insurance.

The problems that Mark and his employees had with government under the present system did not end with the state legislature. Federal tax law also interfered. If Mark's company purchased the insurance, it could pay with pretax dollars. But if employees purchased insurance on their own, they had to pay with aftertax dollars. If federal tax law had been designed for individuals rather than for companies, it would have permitted a full range of options for each employee. In that case, not all employees would be forced to accept the same package of health insurance benefits. Each could choose among competing health insurance plans and purchase the

policy with nontaxed dollars (the same way their employers do now).

Making Senator Blake's Life Easier

Senator Blake's principal problem stemmed from the federal government's attempts to do something of which it is incapable: operate a giant insurance company. Moreover, as in the case of private health insurance, Medicare insurance has long since ceased to be genuine insurance—it is instead prepayment for the consumption of medical care. Thus, Senator Blake and his colleagues must decide who gets to consume what and how much—an unpleasant task.

To make matters worse, decisionmakers such as Blake are continually pressured by special interests. Not surprisingly, by the time all of the pressures have sorted themselves out, Medicare has violated every principle of sound insurance. That is not unusual. In every field in which the government operates an insurance program, sound insurance principles are sacrificed to political pressures.

Is there a way of replacing Medicare with a program that takes advantage of private-sector strengths in providing the elderly with health care? Yes—and at least one country, Singapore, has made substantial progress toward implementing a totally private system. We will examine emerging market-based systems in later chapters.

The market for medical care will never be exactly like the market for corn or wheat, but there is no reason why we cannot create a similar institutional framework. We can transfer the power to make important decisions from large institutions such as government, corporate employers, insurance companies, and hospitals to individuals. We can allow supply, demand, and competition to allocate resources. Consumer preference and individual choice can determine the ultimate form of our health care system.

2. Two Competing Visions of the Health Care System

Within the last several years, dozens of proposals to reform the U.S. health care system have been produced by task forces, government agencies, and private groups. Almost all have had one thing in common: They have adopted the same vision of the medical care marketplace that has dominated the U.S. health care system since the end of World War II.

An exception was a task force report issued in May 1990.[1] The task force was composed of representatives from 40 universities and research organizations, including the American Enterprise Institute, the Hoover Institution, and the Cato Institute. The report was published by the National Center for Policy Analysis (NCPA) in Dallas. What made the NCPA report radically different was its endorsement of a different vision of how the medical marketplace could function. Whereas other proposals called for enlargement of the role of third-party insurers, the NCPA report called for less reliance on third-party insurance and more reliance on individual self-insurance. Whereas other proposals called for larger bureaucracies and greater centralization, the NCPA report called for decentralization and competitive markets. Whereas other proposals implicitly accepted the idea that the medical marketplace cannot function like other markets, the NCPA report sought ways to reap the benefits of competition and consumer choice for the health care delivery system.

In this chapter, we develop more fully the distinction between the vision proposed in the NCPA report and the vision accepted by most other health policy commentators. In the following two chapters, we present the task force's specific recommendations and show how they can be used to solve major health policy problems.

[1]Task Force Report, *An Agenda for Solving America's Health Care Crisis*, NCPA Policy Report no. 151 (Dallas: National Center for Policy Analysis, May 1990).

How the Medical Marketplace Differs from Other Markets

In a normal market, major problems are solved by individual initiative on the part of consumers and producers pursuing their own self-interests. Consumers circumvent waste, inefficiency, and resulting high prices by searching for good products at attractive prices offered by efficient suppliers. Producers search for less costly ways of meeting consumer needs. Pursuit of self-interest by consumers rewards the most efficient producers, and pursuit of self-interest by producers rewards consumers.

In the health care sector, however, normal market processes have been replaced by bureaucratic institutions and normal market incentives by bureaucratic rule making. As a result, the scope for individual initiative is greatly restricted, and often people can pursue their own interests only by creating costs for others. For example:

- Whereas consumers in a normal market spend their own money, in the medical marketplace consumers are usually spending someone else's money. Only 5 cents out of every dollar of hospital income and only 19 cents out of each dollar of physicians' fees is paid by patients using their own funds.
- Whereas producers in a normal market continuously search for ways to reduce costs, when physicians and hospitals increase costs, they often also increase their incomes. Their success depends less on service to patients than on meeting the requirements of third-party (government and private insurance) reimbursement formulas.
- Whereas individuals in other insurance markets may choose from diverse products, the vast majority of people who have health insurance are covered under an employer or government plan. Despite so-called cafeteria options, an individual usually cannot purchase a less expensive plan with a different type of coverage without making considerable personal sacrifice.
- Whereas innovation and technological change in a normal market are viewed as good for consumers, third-party payers in the medical marketplace are increasingly hostile to new technology and discourage its development.
- Whereas producers in a normal market advertise price discounts and quality differences, most patients in the hospital

> marketplace cannot find out what the cost will be prior to admission and cannot read the hospital bill upon discharge. Patients rarely can obtain information about the quality of physicians or hospitals, even when quality problems are well-known within the medical community.

The result is a marketplace in which the pursuit of self-interest often does not solve problems, but creates them instead. When consumers consume, they drive up insurance premium costs for other consumers. The primary ways in which physicians and hospitals increase their incomes also lead to increasing insurance premiums. Rarely can individuals act to change things without operating through large bureaucracies, and when bureaucracies attempt solutions, their "success" usually creates new problems and new costs for other bureaucracies.

How America's Health Care Crisis Evolved

In most Western industrial democracies, health care systems shaped by government policies have evolved through three stages.

The Cost-Plus System of Health Care Finance (Stage I)

From the end of World War II through the mid-1980s, Americans paid for hospital care principally through a cost-plus system of health care finance. Cost-plus reimbursement worked like this: If Blue Cross patients accounted for 25 percent of a hospital's patient days, Blue Cross reimbursed the hospital for 25 percent of its total costs. If Medicare patients accounted for 30 percent of the hospital's patient days, Medicare paid the hospital 30 percent. Other insurers reimbursed in much the same way.[2] Health insurance literally ensured that hospitals had enough income to cover their costs and health insurers acted as agents not for their policyholders, but for the suppliers of medical services. Because the only way the suppliers could increase their incomes was to increase costs, the cost-plus system invariably led to rising health care costs.

[2]See John C. Goodman and Gerald L. Musgrave, *The Changing Market for Health Insurance: Opting Out of the Cost-Plus System*, NCPA Policy Report no. 118 (Dallas: National Center for Policy Analysis, September 1985). The cost-plus system is described in detail in chapters 5, 6, and 7 of this book.

A cost-plus system could never exist if patients were spending their own money in a competitive marketplace. Therefore, the prerequisite for cost-plus medicine was a market in which the supply side was dominated by nonprofit institutions that competed in only limited ways. The demand side was dominated by large, third-party bureaucracies that were more responsive to the needs of sellers of medical services than to the needs of the insured. By the 1970s, those institutions were well in place.[3]

In a cost-plus system, the pressures to increase spending on health care were inexorable. Patients had no reason to show restraint, since the funds they spent belonged not to them but to third-party institutions. When they entered the medical marketplace, they were spending someone else's money, not their own.

Physicians often believed that the "pure" practice of medicine could and should be free from the constraints of money. In prescribing tests and other medical treatments, physicians not only did not think about costs, they had no idea what those costs were. Guided by the sole consideration of patient health, physicians were inclined to do anything and everything that might help the patient—restrained only by the ethical injunction to do no harm.

The system in its pure cost-plus phase rewarded scientists, inventors, and research and development personnel. The message of the medical marketplace was, "Invent it, show us it will improve health, and we will buy it, regardless of the cost."

The role of the hospital was to provide an environment in which cost-plus medicine could be practiced, in which all of the latest technology was available, within easy reach and on demand. In such a world, hospital administrators did not manage doctors. To the contrary, they served the physicians' interest in practicing medicine by interfering as little as possible in the physicians' activities.

Such a hospital environment would be inconceivable were it not for a system that reimbursed hospitals on the basis of their costs. The role of third-party payers in the system, therefore, was to pay whatever bills were submitted, with few questions asked. Cost

[3]For an analysis of how these institutions evolved, see John C. Goodman, *The Regulation of Medical Care: Is the Price Too High?* (Washington: Cato Institute, 1980). A different perspective, one more sympathetic to the suppression of market incentives, is presented in Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

increases were passed along to policyholders in the form of higher health insurance premiums.

The Cost-Plus System in Its Cost-Control Phase (Stage II)

Because there is a limit to how much any society will pay for health care, the cost-plus system was ultimately forced to limit the decisions of the suppliers of medical care in arbitrary ways. The limitations took the form of rules and restrictions written by impersonal bureaucracies, far removed from the doctor/patient relationships they sought to regulate.

During the 1980s, the U.S. health care system evolved from a pure cost-plus system (Stage I) into a cost-plus system in its cost-control phase (Stage II). In this second stage, there are many different third-party paying institutions, some public and some private. Each is engaged in a bureaucratic struggle—not merely to resist the cost-plus push of the medical care providers, but also to reduce its share of the total cost. Each separate third-party institution is free to initiate its own cost-control strategy in random and uncoordinated ways. But since the basic structure of cost-plus finance has not changed (that is, no real market has been created), Stage II only secondarily is about holding down total spending. Primarily, it is about bureaucratic warfare over shifting costs.

The central focus of third-party paying institutions is to eliminate "waste." Yet bureaucratic institutions (operating principally through reimbursement strategies chosen by people remote from actual patients and doctors) usually cannot eliminate waste without harming patients. Third-party payers may seek to eliminate waste by controlling price, or quantity, or both. In the very act of trying to control prices, however, they invariably focus on a normal price for a normal service, ignoring patients and institutional settings that are not normal. In the very act of trying to control quantity (for example, by eliminating "unnecessary" surgery or "unnecessary" hospital admissions), they again invariably set standards for what is normal—ignoring the unanticipated, abnormal circumstances in which medical care is often delivered.

On the supply side of the medical marketplace, institutions have great resources and considerable experience at resisting change. So, in the face of a cost-control measure initiated by one institutional buyer, the suppliers attempt to shift costs to another, without changing their fundamental behavior. The suppliers are sufficiently

adept at this so that, over the long haul, costs are not really controlled in Stage II. At best, each new wave of buyer restrictions slows the rate of increase. But after suppliers adjust to the new restrictions, costs rise again. Precisely for this reason, a system in Stage II evolves into Stage III. It is in this final stage that institutional buyers acquire the ultimate weapon in the cost-control battle—the power of government.

Evolution to National Health Insurance (Stage III)

In the final phase of the cost-plus system's evolution, third-party payers directly or indirectly control the entire system. They begin to determine what technology can be used, what constitutes ethical behavior in the practice of medicine, even what illnesses can be treated and how. Ultimately, they determine who lives and who dies.

In most countries with national health insurance, many of the perverse incentives that were present in Stage I are still in place. The appetite to spend is held in check, or misdirected, by rules and regulations enforced either directly by government or by insurance company proxies for government. In this third stage, government not only controls the total amount of spending on health care but also actively intervenes in the allocation of health care dollars. Stage III is pure special-interest warfare, fought out in the political arena. It takes all of the struggles present in Stage II and elevates them to the realm of politics.[4]

How the Cost-Plus System Affects Patients

In Stage I of the evolution of a cost-plus system, the quality of medical care delivered may be very high. That is because medical care is administered in an environment in which cost is no object, and physicians are trained to do everything possible to alleviate any and all illnesses, real or imagined. Once the system enters its cost-control phase, however, the quality of care can deteriorate rapidly. That is because competing institutions begin a monumental struggle over resources. In this environment, the patient is no longer seen as a consumer or buyer of medical care. Indeed, individual patients are largely unimportant except insofar as their formal

[4]See "The Politics of Medicine" in John C. Goodman, *National Health Care in Great Britain: Lessons for the USA* (Dallas: Fisher Institute, 1980), ch. 10.

consent is needed to legitimize the bureaucratic warfare over vast sums of money.

The Role of Insurance

Outside of the health care sector, there are well-developed markets for insurance for a wide variety of unforeseen, risky events: life insurance (for an unforeseen death), automobile liability insurance (for an unforeseen automobile accident), fire and casualty insurance (for unforeseen damage to property), and disability insurance (for unforeseen physical injuries). Indeed, there is hardly any risk that is not, in principle, insurable. Lloyd's of London will even insure against the failure of a communications satellite to achieve orbit, and it wrote coverage for ships in the Persian Gulf and off the coast of Israel from the day Operation Desert Storm began.

All of these markets have certain common characteristics.[5] The amount to be reimbursed is based on a risky event. Once the event has occurred and the damage has been assessed, the insurer writes a check to the policyholder for the agreed-upon amount. Policyholders are free to do whatever they prefer with the money they receive.

In the market for health insurance, however, things are very different. Often, there need not be any risky event to trigger insurance payments. (June Adams, for example, had had tension headaches for years.) Once it is determined that a health insurer owes something, the amount to be paid is not a predetermined sum but is instead determined by the consumption decisions of the policyholder. (Jeff Adams, for example, chose to have surgery in a hospital rather than as an outpatient, and June Adams elected to undergo a battery of tests.) Finally, payment is made not to the insured but to medical providers, based on the consumption decisions that are made.[6] These differences shape the way the health insurance market functions. In fact, in many respects health insurance is not insurance at all. It is instead prepayment for the consumption of medical care.

[5]An exception is insurance for tort liabilities, which has many of the defects of health insurance and leads to many of the same problems.

[6]There are a few exceptions, such as policies that indemnify patients in the form of a fixed sum of money per day spent in the hospital for a procedure or a diagnosis (for example, cancer).

Because health insurance is the primary method of payment for the medical services Americans consume, in a very real sense it is the insurer rather than the patient who is the customer of medical providers. Thus, June Adams and Jeff Adams were not the principal buyers of the medical care they received. Blue Cross was. Similarly, Irene Adams and Mr. Hansen were not the principal buyers of their medical care. Medicare was.

The Relationship between Buyer and Seller

In a normal marketplace, buyers and sellers negotiate over price, quantity, quality, and other terms for big-ticket items or important transactions. For smaller, frequent, and less critical transactions, buyers search for the most favorable terms or conditions. Sellers adjust terms and conditions to meet customers' needs and to react to the offers of their rivals. An exchange is not consummated unless it benefits both parties. The preferences of other people, not parties to the exchange, are rarely considered. In the medical marketplace, however, things are very different.

In reflecting on the experiences of the hypothetical Adams family, it is interesting to note that there was never a real exchange. That is, there was no case in which a buyer and seller reached a mutually beneficial agreement, independent of the wishes of others. To the contrary, in every case an entity (for example, government or an insurance company) not a party to the exchange was far more important in determining what ultimately happened than the parties who interacted.

In the cases of Jeff, June, and George Adams, the medical procedures performed were far more influenced by the reimbursement policies of private insurers than by any mutually beneficial exchange between patients and their doctors. In the cases of Irene Adams and Mr. Hansen, what was done or not done was virtually unaffected by the preferences of the patients and their families. Instead, the decisions of the medical providers were determined exclusively by the Medicare bureaucracy.

When the legislators in some distant city decided what elements had to be contained in a group health insurance policy, none of them asked Mark Adams or his employees what their preferences were. So, unlike their counterparts at Williams, Inc., Mark Adams and his employees never had the opportunity to find a scaled-down

policy that the company could afford. The decision to end group health insurance at Mark Adams's company was not a mutually beneficial agreement between employer and employees. It was an outcome dictated by politicians who didn't even know Mark Adams and the people who worked for him.

In the medical marketplace, rules imposed by third-party institutions increasingly shape medical practice. When Medicare patients interact with the health care system, *what* procedures are performed—and *whether* a procedure is performed—is determined more by reimbursement rules than by patient preferences or the physician's experience and judgment. Although this phenomenon is more evident in government health care programs (Medicare and Medicaid), private insurers and large companies are increasingly copying the methods of government.

The Role of Information

One of the most striking things about the Adams family's experiences is how little information the people had. Those making decisions lacked not only information about the monetary cost of those decisions, but often the information that could have saved their lives.

Consider the differences between the experiences of the Adams family and our everyday experiences in nonhealth care markets. Jeff Adams agreed to hospital surgery with no idea what it would cost him. When he was discharged, he was presented with a statement that he could not read or understand. He assumed Blue Cross would look out for his interests, but he had no idea how Blue Cross handled claims. Unquestionably, there is no other market in which Jeff Adams could be a buyer (including the market for any other type of insurance) in which anything even remotely similar takes place.

In almost every other market, the biggest problem that sellers have is getting information to prospective buyers. Those who have a better product or a better way to meet consumer needs often go to great expense to convey the information to potential customers. But in the experiences of the Adams family, precisely the reverse was true. In fact, in example after example, essential information was intentionally concealed and withheld.

George Adams, for example, had no idea that his pacemaker was not of the highest quality or that better products existed. The person

in the best position to tell him about the options (his physician) didn't do so. Irene Adams, who died of lung cancer, did not understand how Medicare works. She didn't know that there were services that she could and should have been purchasing with her own money. Again, the person in the best position to tell her (her physician) failed to do so. In all probability, when Mr. Hansen came to the emergency room, no one explained to the Hansen family the options, and the probable costs and risks associated with each.

Why is vitally important information persistently withheld and concealed in the medical marketplace? Because in the health care sector, people discover that it is in their self-interest to withhold information. In general, medical equipment manufacturers, pharmaceutical companies, and other suppliers with information about quality do not communicate the information to patients because they do not view patients as the principal buyers.[7] Their principal customers are hospitals, physicians, and third-party institutions. Patients frequently do not have information about quality for yet another reason. In an effort to suppress competition among providers, associations of physicians and hospitals have made it difficult, if not impossible, for patients to get information about quality. Avoiding quality comparisons has become a matter of professional ethics. In the past, adherence to such ethical codes was backed by the force of state law. As a result, in most communities patients cannot even discover the mortality rate for surgery and for specific surgeons at public hospitals funded by the patients' own tax dollars.

An Exception: Cosmetic Surgery

In one area of the medical marketplace, cosmetic surgery, most of the generalizations made above are no longer true. In general, cosmetic surgery is not covered by any private or public health insurance policy. Yet, in every major city, it is thriving. Patients pay with their own money and, despite the fact that many separate fees are involved (payments to the physician, nurse, anesthetist or anesthesiologist, hospital, etc.), patients are almost always given a fixed price in advance—covering all medical services and all hospital charges.[8] Patients also have choices about the level of service

[7]In some cases they are prohibited by law from communicating the information.

[8]To our knowledge, no one has studied the market for cosmetic surgery. That is unfortunate because most of what employers and insurers have unsuccessfully tried to accomplish for other types of surgery over the past decade has occurred naturally with few problems and little fanfare in the market for cosmetic surgery.

(for example, surgery can be performed in a physician's office or, for a higher price, on an outpatient basis in a hospital). Many readers will be aware of the recent controversy over the potential risk to patients of (silicon) breast implants. They may not be aware that there are dozens of medical procedures—far more risky for patients and about which there is considerable disagreement in the medical community—that are not investigated by the federal Food and Drug Administration (FDA) and routinely reported on by the national news media. Overall, patients probably have more information about quality in cosmetic surgery than in any other area of surgical practice.

The characteristics of the market for cosmetic surgery also are evident in other medical markets in which patients are paying with their own funds. For example, private-sector hospitals in Britain frequently quote package prices for routine surgical procedures. And U.S. hospitals often quote package prices to Canadians who are willing to come to this country to get care that is being rationed in Canada.

Vision of an Ideal Health Care System

Before we recommend solutions to America's health care problems, we need a clear idea of where we want to go. That is, we need a vision of an ideal medical marketplace in order to plan the steps that will take us there. By "ideal," we do not mean a visionary world in which there are no problems. The ideal medical marketplace is simply one that works at least as well as most other markets in which we buy and sell.

Goals of an Ideal Health Care System

We can identify five goals of an ideal health care system. In the very act of reaching these goals, we would be simultaneously solving America's health care problems. Specifically, an ideal system would seek to:

- Transfer power from large institutions and impersonal bureaucracies to individuals.
- Restore the buyer/seller relationship to patients and medical suppliers, so that patients (rather than third-party insurers) become the principal buyers of health care.

- Create institutions in which patients (as much as possible) spend their own money, rather than someone else's, when they purchase health care.
- Remove health care (as much as possible) from the political arena, in which well-organized special interests can cause great harm to the rest of us.
- Subject the health care sector to the rigors of competition and create market-based institutions in which individuals reap the full benefits of their good decisions and bear the full cost of their bad ones.

How an Ideal Health Care System Would Function

In a health care system designed to pursue the goals listed above, the roles of patients, physicians, hospitals, insurance companies, employers, and even government would be radically different. The principal differences would be that:

- Patients rather than third-party payers would become the principal buyers of health care, with opportunities to compare options, compare prices, and make decisions.
- Physicians would no longer serve as the principal agents of third-party payers, but would serve as the principal agents of patients and help them to make informed choices.
- Hospitals would no longer serve as the principal agents of either physicians or third-party payers, but would become competitors in the business of health care delivery and would compete for patients by improving quality and lowering prices.
- Health insurance companies would no longer be buyers of health care, but would specialize in the business of insurance and reimburse policyholders in the case of unforeseen and risky adverse health events.
- Employers would not be buyers of health care and would not make decisions for employees concerning their health insurance, but would be agents for individual employees and help them to make informed choices and to monitor the performance of competing insurers.
- Government—in its role as an insurer of last resort—would no longer serve as a buyer of health care but would pay health insurance premiums for indigent policyholders.

- Government—in its policymaking role—would facilitate the goals of the system on the demand side by encouraging private savings for small medical bills, private health insurance for large medical bills, and lifelong savings for medical needs during retirement; on the supply side, government would encourage free and open competition in the markets for physicians' services, hospital services, and private health insurance.

If the ideal is so obvious, why hasn't the private sector implemented it? The answer is that virtually every private-sector action that would move us in the direction of the ideal health care system is discouraged by government policy. In the next chapter we examine these government-created obstacles in detail and consider the policy changes needed to remove them.

Implementing the Ideal: The Health Care System of Singapore

Singapore's health care system is part of a much wider system based on an explicit goal: no government subsidies. The government of Singapore has attempted to identify all of the major needs that other governments approach with welfare and entitlement programs and to meet those needs by requiring people to save. In Singapore, personal savings accounts are replacing the welfare state.

For example, instead of a government-run social security system, Singapore's residents are required to save for their own retirement. Instead of a government-run health care system, people are required to place 6 percent of their annual income in medical savings accounts. Funds build up in these accounts tax free and can be spent only on medical care. The program of forced savings also covers other needs. Required (retirement) savings can be used to buy life insurance and disability insurance, make a down payment on a home, or finance a child's college education.

The philosophy of Singapore is: Each individual should pay his or her own way; each family should pay its own way; and each generation should pay its own way. Government transfers should be minimal. Progress toward that goal has been remarkable. Over the last decade, savings account balances have soared and government spending on traditional welfare programs has decreased dramatically.

With respect to health care, the Singapore system makes sure that money spent on medical services is in the hands of the consumers of those services. In general, 6 percent of a person's income over an entire working life will pay for hospitalization for the vast majority of medical episodes that can occur, and only recently has Singapore introduced catastrophic health insurance to pay for large medical bills.

Singapore is far from perfect. Readers of the *Wall Street Journal* are well aware that Singapore practices censorship, and the government violates other civil rights as well. Health economists will have no difficulty in spotting defects and recommending improvements in the country's health care system. Nonetheless, there is great value in studying carefully Singapore's system, and we shall examine it more closely in chapter 18.

Can Patients Function as Informed Consumers in the Medical Marketplace?

The most common objection to using markets to solve health care problems relates to the complexity of medical decisions and the inability of patients to make wise choices. Medical science is complicated and becoming more so. Moreover, most medical episodes (such as gall bladder malfunction) occur only once in a person's lifetime. Given that, for any one person, such episodes occur infrequently, individual patients cannot be expected to learn from experience or to invest much time, energy, and money in learning about a medical procedure on the slight chance that they may need it some day. How then, even under the best of circumstances, can patients make wise decisions about whether to have gall bladder surgery, what physician to use, and what hospital to enter?

The answer is that they must rely on the advice of others. Short of going to medical school themselves, there is no alternative. However, just because we must depend on others for advice does not mean that we should surrender power to them.

The primary difference between markets and nonmarket bureaucracies is consumer sovereignty. In general, the more complicated a market, the stronger the case for consumers' not surrendering the power to make ultimate decisions. If choosing a physician is complex, choosing a politician who will appoint a bureaucrat to choose a physician is even *more* complex. Elevating choices to the

realm of politics only makes the choices harder. In selecting a politician, we consumers would not simply be selecting a doctor-chooser; we would be selecting a person who would make many other decisions affecting our lives. If choosing the wrong doctor can cause harm, then choosing the wrong politician to choose the doctor for us can cause even more harm. What is true of politicians is also true of employers, insurance companies, and any other bureaucracy.

Imagine you live in a country with national health insurance, in which health care is routinely and arbitrarily rationed by the medical bureaucracy. Knowing the institutional setting, you are predisposed to distrust the advice you receive from a physician. If told that you do not need an expensive diagnostic test or surgical procedure, you have no way of knowing whether the advice represents state-of-the-art medicine or potentially lethal rationing. Discovering whether you really need an expensive procedure is only half the problem. Once you know you need it, you still have to cope with the complexities of bureaucratic rationing. Getting to the head of the line is, in itself, a skill and an art. Unless you are willing to totally give up control and do whatever physicians tell you, your problems in a bureaucratic system are even more complex than in a market system.

An important principle to remember is: No one cares more about you and your family than you do. And the further removed decisionmakers are from you and your family—geographically, economically, and politically—the less likely they are to make the same decision you would have made with respect to your health care. Another important principle is: We can often take advantage of the wisdom and experience of others without transferring power to them. If politicians have wise advice to give, we can take their advice while retaining the ultimate authority to make our own decisions.

Precisely because the medical marketplace is complex, employers, insurance companies, governments, health organizations, and nonprofit entities collect and assimilate information that no single patient (or physician) would ever collect individually. The concept behind "managed care," for example, is that organizations can collect information and use it to raise the quality and reduce the cost of medical care—especially with respect to complicated and

expensive procedures. Whether the goal is reached depends on the institutional environment. In a market-based system, organizations that specialize in collecting information can be valuable to both patients and physicians. In a bureaucratic system, such organizations are used to control the behavior of patients and physicians. One system uses information to help people reach their own goals, the other to prevent them from doing so.

In market-based systems, people find it in their self-interest to communicate information to consumers. In bureaucracies, the reverse is true. The more information consumers have, the harder life is for bureaucrats. Dissemination of knowledge is good for the life of markets—it makes them work better—but it is bad for the life of bureaucracies.

The U.S. health care system is far more bureaucratic than most people know. Perhaps, for this reason, too much information is communicated by cranks and quacks, too little by responsible parties. Yet there are welcome signs of change. The cover story of a 1990 issue of *U.S. News & World Report* was entitled "America's Best Hospitals: A National Guide That Helps You Choose."[9] The fact that the article was a cover story shows how rare and unusual it is for such information to be communicated to the general public. A recent book published by Consumers Union (also the publisher of *Consumer Reports*) is entitled *The Savvy Patient: How to Be an Active Participant in Your Medical Care.*[10] What is astonishing is that the book is new. Consumers Union has been in existence since 1936.

Information about the quality of medical practice has been available to the intellectual and economic elite for some time, through various formal and informal sources. For example, *Town and Country* subscribers, who have a median annual income of $98,200 and a median net worth of $875,400, could consult "Town and Country's Exclusive Directory of Outstanding Medical Specialists in the U.S."[11] Now readers of such publications as *Good Housekeeping* can

[9]*U.S. News & World Report,* April 30, 1990.

[10]David R. Stutz, Bernard Feder, and the editors of Consumer Reports Books, *The Savvy Patient: How to Be an Active Participant in Your Medical Care* (Mount Vernon, NY: Consumer Reports Books, 1990).

[11]Stephanie Bernards Johns, "Town and Country's Exclusive Directory of Outstanding Medical Specialists in the U.S.," *Town and Country,* October/November 1989.

refer to surveys of academic department chairs and section chiefs of major medical centers.[12] Publishing these lists is consistent with the growing realization that individuals not only can influence their own health care status by lifestyle choices but also can influence the outcome of their own treatment by judicious selection of hospital, mode of treatment, and physician.

The most important conclusion that follows from the observation that the medical marketplace is complex is the necessity of creating an institutional environment in which "experts" will find it in their self-interest to give us accurate information and wise advice. And the best way to create that environment is to empower patients by giving them greater control over health care dollars. Let us now turn to ways in which public policies can be changed to help achieve that goal.

[12]Maxine Abrams, "The 400 Best Doctors in America," *Good Housekeeping*, March 1991.

3. Moving toward the Ideal: An Agenda for Change

The message coming to our shores from virtually every corner of the globe is: Free markets work and socialism, collectivism, and bureaucracies do not. For the most part, Americans find that message a welcome one. But in the area of health care, the message is falling on deaf ears.

It is worth repeating, therefore, why the message is true. In a market system, the pursuit of self-interest is usually consistent with social goals. When one individual pursues his own interest, his actions usually benefit others as well. Precisely the reverse is true in bureaucratic, nonmarket systems. The social goal may be clearly articulated, but each individual in the bureaucratic system finds it in his self-interest to take actions that defeat that goal.

The hallmark of bureaucratic thinking is the belief that individuals don't matter. All that matters is the social plan and the intelligence and ability of the people administering it. The hallmark of the economic way of thinking is the realization that neither the plan nor the people who administer it matter very much. What really matters is what is in the self-interest of the individuals who actively participate in the system.

Viewed in this way, it is obvious that we cannot solve America's health care crisis if 250 million Americans find it in their self-interest to act in ways that make the crisis worse. By contrast, the crisis will be solved if 250 million Americans find it in their self-interest to take actions that promote solutions. Accordingly, this chapter explores ways of changing the institutional environment in which health care is delivered, with the goal of making problem-solving a matter of individual self-interest.

We cannot dismantle the current health care system overnight. We can move in the right direction, however, by adopting policies that promote the development of an ideal system and by eliminating

policies that make such a system unattainable. The policy agenda described in this chapter is designed to remove harmful, government-created obstacles and to create new incentives under which people will be encouraged to solve problems through individual initiative and choice. Specifically, this agenda would

- Give individuals greater opportunity to purchase no-frills catastrophic insurance for a reasonable price.
- Give individuals greater opportunity to choose among competing health insurance plans and to select the type of coverage best suited to their individual and family needs.
- Give individuals the opportunity to choose between employer-provided group health insurance and individual or family policies—without income tax penalties.
- Give individuals the opportunity to choose between self-insurance and third-party insurance for small medical bills—without income tax penalties.
- Give individuals the opportunity to choose health insurance plans with effective cost-control techniques and to realize the financial benefits from making such choices—without income tax penalties.
- Give individuals the opportunity to build a reserve of savings for future medical expenses, so that they can rely less on third-party insurance and reduce their annual health insurance premiums.
- Give individuals greater opportunity to compare prices in the hospital marketplace and realize the financial benefits of prudent buying practices.
- Give people covered by Medicare and Medicaid opportunities to avoid the harmful effects of health care rationing.
- Give suppliers of medical services new opportunities to search for cost-reducing ways of delivering medical care.
- Give all participants in the medical marketplace an opportunity to avoid the costly effects of the tort system through voluntary contract and exchange.
- Give local communities new options to meet the needs of underserved populations and to create a genuine safety net—unburdened by restrictive, cost-increasing regulations.

- Give rural residents and the urban poor new opportunities to meet their health care needs—unburdened by unnecessary, cost-increasing regulations.
- Give physicians and hospitals providing charity care a fairer way to receive compensation for their services.
- Give all Americans the opportunity to gain from a more rational expenditure of public health care dollars.

Fifteen Policy Proposals

In what follows, we briefly describe 15 changes that are needed and the reasons for these changes.[1] Many of these issues will be discussed at greater length in other chapters in this book.

1. Establishing Equity in Taxation

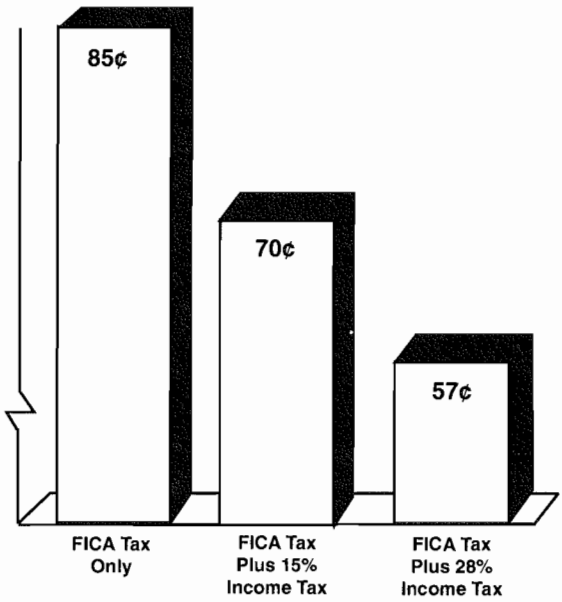
Under current law, health insurance provided by an employer is excluded from the taxable wages of the employees, but insurance premiums paid by individuals are not tax deductible. Consequently, some people realize generous tax advantages from the purchase of health insurance, while others do not. A reasonable solution is to grant the same tax treatment with respect to health insurance to all Americans, regardless of employment and regardless of who purchases the health insurance policy—an individual, employer or self-employed person.

As Figure 3.1 shows, workers in the 28 percent federal income tax bracket face a marginal tax rate of 43.3 percent, leaving them with less than 57 cents in take-home pay out of each additional dollar of earnings. If state and local income taxes also apply,[2] the situation is much worse. Indeed, millions of American workers take home less than 50 cents of each dollar of earnings. Such high tax rates give employers and employees strong incentives to replace wages with nontaxable health insurance benefits, even if health insurance would not otherwise have been purchased. The total tax deduction for employer-provided health insurance is about $60 billion per year, or roughly $600 for every American family. Yet

[1]The policy agenda described in this chapter is based on solutions proposed in Task Force Report, *An Agenda for Solving America's Health Care Crisis*, NCPA Policy Report no. 151 (Dallas: National Center for Policy Analysis, May 1990). The first 10 points included here are taken from the task force report; the final 5 have been added.

[2]Tax rate equals 6 percent.

Figure 3.1
TAKE-HOME PAY FROM AN ADDITIONAL DOLLAR OF WAGES*



*Includes employer's share of FICA taxes.

most of the 34.4 million individuals who do not have health insurance (including about 18.8 million with a family member in the workforce[3]) and about 12 percent of insured individuals who purchase health insurance on their own receive no tax subsidy. As a result, some employees of large companies have lavish health insurance, totally tax deductible, while other Americans have none.

In general, the value of the right to exclude health insurance coverage from taxable wages ranges from about $1,200 per year in reduced taxes for an auto worker to about $300 for a worker in the

[3]Jill D. Foley, *Uninsured in the United States: The Nonelderly Population without Health Insurance* (Washington: Employee Benefit Research Institute, April 1991), Table 1, p. 21.

retail trade.[4] Yet, self-employed individuals,[5] the unemployed, and employees of firms that do not provide health insurance receive little or no tax deduction for the health insurance they purchase. Not surprisingly, people respond to such incentives. About 92 percent of Americans who have private health insurance acquired it through an employer.[6] The more generous the tax subsidy, the more likely people are to have health insurance. Those most likely to be uninsured are people who receive no tax subsidy.

If it is desirable for people to have health insurance, and if we care about equity, then all Americans should receive the same tax encouragement to purchase health insurance, regardless of employment. Accordingly, the self-employed, the unemployed, and employees who purchase health insurance on their own should be entitled to a tax deduction or tax credit that is just as generous as the tax treatment they would have received if their policies had been provided by an employer. (This issue is considered in greater detail in chapter 9.)

2. *Equalizing Tax Advantages for Families with Unequal Incomes*

Under the current system, the ability to exclude employer-provided health insurance from taxable income is more valuable to people in higher tax brackets. However, if it is socially desirable to use the income tax system to encourage families to purchase health insurance for large medical bills, then all families should receive the same encouragement.

For a low-income worker who is paying no income tax, federal tax law makes a dollar of health insurance benefits equivalent to $1.18 in wages. For a worker who is in the 28 percent bracket and paying the Social Security (FICA) tax, a dollar of health insurance benefits is equivalent to $1.76 in wages.[7] Because the value of the

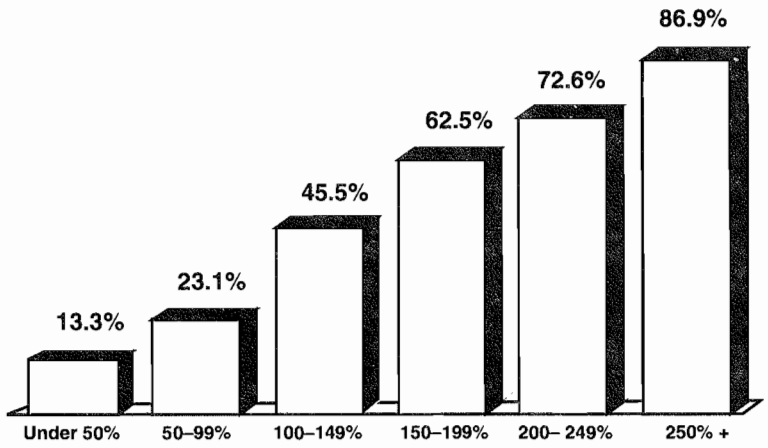
[4]Aldona Robbins and Gary Robbins, *What a Canadian-Style Health Care Scheme Would Cost U.S. Employers and Their Employees*, NCPA Policy Report no. 145 (Dallas: National Center for Policy Analysis, February 1990).

[5]Currently, the self-employed are allowed to deduct 25 percent of health insurance premiums, a deduction that must be periodically reaffirmed by Congress and is threatened in every congressional budget negotiation.

[6]Foley, Table 17 (pp. 46–47).

[7]The value of the benefit equals 1/(1-t), where t is the marginal federal income tax rate plus the combined employer-employee Social Security payroll tax rate. For a worker in the 15 percent bracket, t = 0.15 + 0.153. For a worker in the 28 percent bracket, t = 0.28 + 0.153.

Figure 3.2
PERCENT OF NONELDERLY POPULATION COVERED BY EMPLOYER-PROVIDED HEALTH INSURANCE, 1989

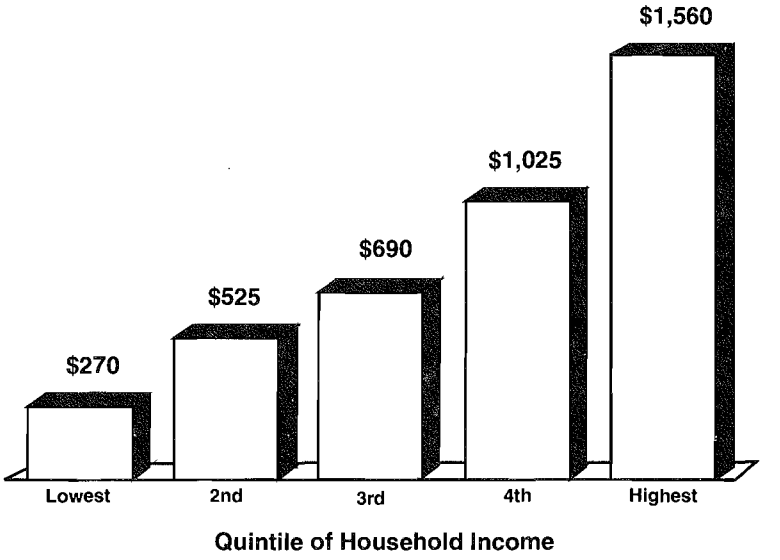


SOURCE: C. Eugene Steuerle, "Finance-Based Reform: The Search for an Adaptable Health Policy," paper presented at an American Enterprise Institute conference, "American Health Policy" (Washington, October 3–4, 1991).

tax subsidy rises with income, it is hardly surprising that the lower a family's income, the less likely the family is to have health insurance. About 61 percent of all people who lack health insurance have annual incomes of less than $20,000.[8] As Figure 3.2 shows, among people with incomes at least 2.5 times the poverty level, about 87 percent have employer-provided health insurance. Only a small fraction of those at or below the poverty level have it, however. As a result, the current system is highly regressive, conferring the largest subsidies on those families with the highest incomes. As Figure 3.3 shows, families in the top fifth of the income distribution receive an annual subsidy of about $1,560 per year. By contrast, families in the bottom fifth receive an annual subsidy of only $270, on the average.

[8]Foley. Not all people who lack health insurance have low incomes. About one-fifth have family incomes in excess of $30,000.

Figure 3.3
AVERAGE VALUE OF ANNUAL FEDERAL TAX SUBSIDIES FOR EMPLOYER-PROVIDED HEALTH INSURANCE, 1992*



SOURCE: C. Eugene Steuerle, "Finance-Based Reform: The Search for an Adaptable Health Policy," paper presented at an American Enterprise Institute conference, "American Health Policy" (Washington, October 3–4, 1991).

*Revenue loss includes both Social Security (FICA) and income taxes.

To give all people the same economic incentives to purchase health insurance, premiums paid by employers should be included in the gross wages of their employees, and all taxpayers should receive a tax credit equal to, say, 30 percent of the premium.[9] That would make the tax subsidy for health insurance the same for all taxpayers, regardless of income and regardless of whether the policies are purchased individually or by employers. For individuals who pay no federal income tax, the tax credit could be made refundable. (This proposal would also have other advantages, as discussed below.)

[9]See the discussion in Stuart Butler and Edmund Haislmaier, eds., *A National Health System for America*, rev. ed. (Washington: Heritage Foundation, 1989).

3. Ending Tax Subsidies for Wasteful Health Insurance

Under the current system, the ability to exclude health insurance from taxable income is unlimited, encouraging some employees to "purchase" too much insurance. To eliminate this problem, the allowable health insurance deduction (or tax credit) should be limited to a premium for no-frills, catastrophic health insurance. Individuals who pay higher premiums for additional coverage should do so without tax subsidy.

The tax law encourages overinsurance in yet another way. A physician's fee paid by an employer (or an employer's insurance carrier) is paid with pretax dollars, whereas fees paid out-of-pocket by employees must be paid with aftertax dollars. As a result, the tax law encourages (subsidizes) 100 percent health insurance coverage (with no deductibles and no copayments) for all medical expenses. Unfortunately, insurance for small medical bills is incredibly wasteful. For one thing, it can cost an insurance company more than $25 to administer and monitor a claim for a $25 physician's fee, thereby effectively doubling the cost of health care. For another, people are far less prudent in purchasing health care if the bills are paid by someone else.

Under the current system, tax-deductible health insurance expenditures range from a high of $3,055 a year under the generous health care plans provided by the automobile manufacturers to as little as $793 a year, which is the average for workers in retail trade. Although this system may appear to benefit large companies with highly paid employees, in the short run many companies are trapped by benefit plans that eat into company profits and raise production costs. In the long run, lavish health plans mean lower aftertax wages. The current system not only encourages and subsidizes rising health care costs but also harms the very industries and companies that are subsidized the most.

To correct this abuse, national policy should encourage individuals to purchase health insurance for catastrophic medical expenses and to save to pay small medical expenses with their own funds.

4. Creating Individual Self-Insurance for Small Medical Bills

The easiest way to hold down health insurance premium increases is to choose policies with high deductibles. On a representative individual health insurance policy for a middle-aged male,

Table 3.1
COST OF EACH ADDITIONAL DOLLAR OF HEALTH INSURANCE COVERAGE IN CALIFORNIA*

Age of Head of Family	Lowering Deductible from $1,000 to $500	Lowering Deductible from $500 to $250
Under 30	$2.52	$2.22
30–39	2.16	3.60
40–49	2.82	4.68
50–59	3.90	5.04
60–64	2.04	10.14

SOURCE: Blue Cross of Southern California, 1991.
*Based on Blue Cross plans sold in Orange, Santa Barbara, and Ventura counties in early 1991.

lowering the annual deductible from $1,000 to $500 costs 64 cents in additional premiums for each additional dollar of insurance coverage.[10] Lowering the deductible from $500 to $250 costs 74 cents in additional premiums for each additional dollar of insurance coverage. Although lower-deductible policies may occasionally be a good buy for a particular individual, they cannot possibly be a good buy for policyholders as a group, who will pay far more in premiums than they will collect in medical benefits.

For people who live in high-cost areas, low-deductible health insurance is even more wasteful. Consider, for example, the costs of lowering the deductible on a Blue Cross family policy in California. As Table 3.1 shows, any deductible lower than $1,000 is a terrible buy unless federal tax law offsets the waste in the manner described above. Suppose a 40-year-old living in Orange County, California, has a Blue Cross family policy with a $250 deductible. If the family chose a $1,000 deductible instead, it would give up $600 of health insurance coverage (since Blue Cross pays only 80 percent of the additional $750 of expenses). But in return, the family would cut its health insurance premiums by $2,064! Savings of this magnitude are not typical. However, this example illustrates dramatically that opportunities for saving do exist in the health insurance market.

[10]These calculations are based on policies sold by Golden Rule Insurance Company, the largest seller of individual and family health insurance policies in the country. Other insurance companies sell similar policies at similar prices.

Despite the fact that low-deductible insurance policies are often wasteful, the tax law encourages such policies and discourages high-deductible policies. On a $1,000-deductible policy, for example, the first $1,000 must be paid out-of-pocket with aftertax dollars. If that $1,000 were paid by employer-provided insurance, the premium could be paid with pretax dollars.

To eliminate the perverse incentives in the current system, individuals should be allowed to choose higher deductibles and deposit the premium savings in individual medical savings (Medisave) accounts. Such accounts would serve as self-insurance for small medical bills. Medisave accounts would be the private property of the account holder and become part of an individual's estate at the time of death. Contributions to Medisave accounts would receive the same tax encouragement as payments for conventional health insurance.[11]

Creating individual and family Medisave accounts (discussed in greater detail in chapter 8) would represent a major departure from the current system of paying for health care. These accounts would have immediate advantages that would become even more important over time. Because Medisave accounts would last over an individual's entire life, they would allow people to engage in lifetime planning—recognizing that health and medical expenses are related to choices that people make throughout their lives. Moreover, Medisave accounts would eventually become an important source of funds from which to purchase health insurance or make direct payments for medical expenses not covered by Medicare during retirement.

5. Creating Freedom of Choice in Health Insurance

The number of Americans without health insurance now totals as many as 34.4 million people.[12] One reason so many lack health

[11]See John C. Goodman and Gerald L. Musgrave, *Controlling Health Care Costs with Medical Savings Accounts*, NCPA Policy Report no. 168 (Dallas: National Center for Policy Analysis, January 1992).

[12]This is the estimate of the Employee Benefit Research Institute; see Foley. Other estimates place the number closer to 30 million. See the review of the literature in Michael A. Morrisey, "Health Care Reform: A Review of Five Generic Proposals," paper presented at a policy forum, "Winners and Losers in Reforming the U.S. Health Care System," sponsored by the Employee Benefit Research Institute Education and Research Fund (Washington: October 4, 1990).

insurance is the existence of state regulations. State-mandated benefits, along with other state regulations, are increasing the cost of health insurance and pricing as many as one out of every four uninsured people out of the market.[13] A reasonable solution is to allow individuals to buy no-frills health insurance tailored to individual and family needs.

In recent years, there has been an explosion of state laws requiring health insurance policies to cover specific diseases and specific health care services. These laws are called mandated health insurance benefit laws. In 1970, there were only 48 such laws in the United States. Today there are more than 1,000, with legislation enacted by every state in the union.

Mandated benefits (examined in greater detail in chapter 11) cover ailments ranging from AIDS to alcoholism and drug abuse, and services ranging from acupuncture to in vitro fertilization. They cover everything from life-prolonging procedures to purely cosmetic devices: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont, and deposits to sperm banks in Massachusetts. These laws reflect the influence of special-interest groups that now represent virtually every disease, disability, and health care service.[14]

Currently, 45 states require health insurance coverage for the services of chiropractors, four states mandate coverage for acupuncture, and two states require coverage for naturopaths (who specialize in prescribing herbs). At least 13 states limit the ability of insurers to avoid covering people who have AIDS or a high risk of getting AIDS. Forty states mandate coverage for alcoholism, 27 states mandate coverage for drug addiction, and 29 states mandate coverage for mental illness. Seven states even mandate coverage for in vitro fertilization.[15]

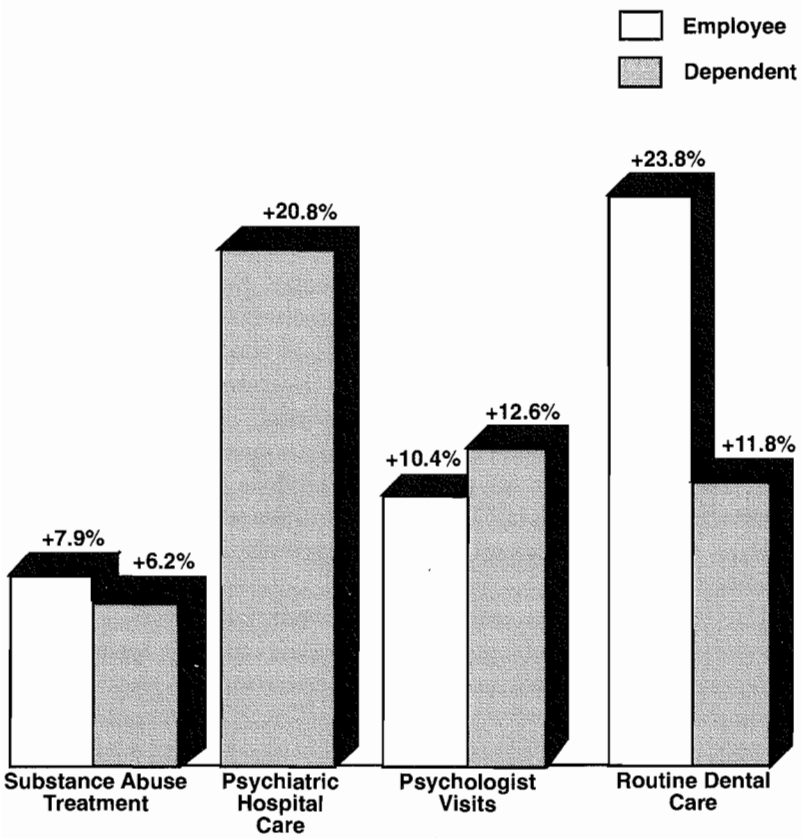
Collectively, state mandates add considerably to the cost of health insurance, and they prevent people from buying no-frills insurance

[13]See John C. Goodman and Gerald L. Musgrave, *Freedom of Choice in Health Insurance*, NCPA Policy Report no. 134 (Dallas: National Center for Policy Analysis, November 1988).

[14]Ibid.

[15]*Health Benefits Letter* 1, no. 15 (August 29, 1991).

Figure 3.4
INCREASES IN INSURANCE PREMIUMS CAUSED BY SPECIFIC HEALTH INSURANCE BENEFITS



SOURCE: Gail A. Jensen (Wayne State University) and Michael A. Morrisey (University of Alabama at Birmingham), "The Premium Consequences of Group Health Insurance Provisions" (September 1988), mimeograph.

at a reasonable price. As Figure 3.4 shows, mandated coverage can increase premiums by 6 to 8 percent for substance abuse, by 10 to 13 percent for outpatient mental health care, and by as much as 21 percent for psychiatric hospital care for employee dependents.

Employees of the federal government, Medicare enrollees, and employees of self-insured companies are exempt from these costly

regulations under federal law. Often, state governments exempt Medicaid patients and state employees. The full burden, therefore, falls on the employees of small businesses, the self-employed, and the unemployed—the groups that are increasingly uninsured.

Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. That freedom is rapidly vanishing. To restore it, insurers should be permitted to sell federally qualified health insurance both to individuals and to groups. This insurance should be free from state-mandated benefits, state premium taxes, and mandatory contributions to state risk pools.

6. Giving Employers and Employees New Options for Cost Containment and Individual Freedom of Choice

Under current employee benefits law, employers have few opportunities to institute sound cost-containment practices without substantial income tax penalties, and employees have few opportunities to purchase less costly or more appropriate health insurance. To eliminate these problems, health insurance benefits should be personal and portable, with each employee free to choose an individual policy that would remain with the employee in case of a job change. Health insurance benefits should be included in the gross wages of employees who would be entitled to tax credits for premiums on their personal tax returns, so that employees reap the direct benefits of prudent choices and bear the direct costs of wasteful ones.

Suppose a small firm considers purchasing an individual policy for each employee to take advantage of the favorable tax treatment of health insurance. As Table 3.2 shows, the firm immediately is faced with four problems. First, the cost of the policy varies with the employee's age (a 60-year-old male, for example, is about four times more expensive to insure than a 20-year-old male). The obvious solution is to pay the premiums for the policies and reduce each worker's salary by the premium amount. Second, not all employees want health insurance (for example, some may be covered by a spouse's policy). The obvious solution is to give health insurance only to those who want it, reducing the salary of each by the amount of the premium. Third, some employees may have preexisting illnesses for which the insurer wants exclusions and riders. The

Table 3.2
SOLVING HEALTH INSURANCE PROBLEMS FOR SMALL EMPLOYERS AND THEIR EMPLOYEES*

Problem	Solution
Costs differ by age, sex, type of job, and other employee characteristics	Reduce each employee's gross salary by the amount of that employee's premium
Not all employees want or need employer-provided coverage	Give health insurance only to employees who want it
Some employees have preexisting illnesses	Negotiate the best coverage possible for each individual employee
Employees have different preferences about health insurance coverage (deductibles, services covered, etc.)	Allow each employee to choose a policy best suited to individual and family needs

*Each of these solutions requires changes in the tax law and employee benefits law to avoid costly tax penalties.

obvious solution is to negotiate the best possible deal for each employee. Fourth, employees may have different preferences about the content of their policies. Some may want to trade off a higher deductible for a lower premium. Others may want coverage for different types of illnesses and medical services (for example, infertility coverage). The obvious solution is to let each employee choose a policy suited to his or her needs and preferences.

Despite the obviousness of these solutions and the fact that each employee may gain from them, they are generally forbidden under federal law. In general, the tax law prevents employees from choosing between wages and health insurance and insists that all be offered the same coverage on the same terms. The result is that the employer must turn to a more expensive group policy with a package of benefits that no single employee may want. To make matters worse, the employer is forced to adopt a health care plan in which benefits are individualized but costs are collectivized.

Although large employers have a few more options, they too are forced into a system that has two devastating defects. First, because there is no direct relationship between health insurance premium costs and individual employee wages, employees see no relationship between the cost of employer-provided health insurance and personal take-home pay. Second, because there is no relationship between imprudent health care purchases and salary under conventional employer health plans, employees have no personal incentives to be prudent buyers of health care.

In the face of constraints imposed by federal policy, employers are trying to hold down health care costs by taking actions that have very negative social consequences. Unable to adopt a sensible approach to employee health insurance, many large firms are asking employees to pay (with aftertax dollars) a larger share of the premium.[16] Often, employers pay most of the premium for each employee, but ask the employees to pay a much larger share for their dependents.[17] Such practices result in some employees' opting not to buy into an employer's group health insurance plan. More frequently, they choose coverage for themselves but drop coverage for their dependents. Indeed, three million people who lack health insurance are dependents of employees who are themselves insured.[18]

Because employee benefits law prevents smaller firms from adopting a sensible approach to employee health insurance, many firms are responding to rising health insurance premiums by canceling their group policies altogether. Often, they then give bonuses or raises to their employees and encourage them to purchase individual health insurance policies (with aftertax dollars) on their own. Many employees, of course, do not do so. One of the great ironies of employee benefits law is that, although it was designed to

[16]In most large companies, employees can pay their share of the premium with pretax dollars under salary-reduction agreements with employers or through "flexible spending accounts." These options exist under section 125 of the Internal Revenue Code. However, the costs of setting up section 125 plans are often prohibitive for small employers. On the options for large employers, see Alain Enthoven, "Health Tax Policy Mismatch," *Health Affairs* (Winter 1985), pp. 5–13.

[17]Kenneth H. Bacon, "Business and Labor Reach a Consensus on Need to Reduce Health Care Costs," *Wall Street Journal*, November 1, 1989.

[18]Employee Benefit Research Institute, *A Profile of the Nonelderly Population without Health Insurance*, EBRI Issue Brief no. 66 (May 1987), p. 7.

encourage the purchase of health insurance, its more perverse provisions are increasing the number of people without health insurance. Because employers cannot individualize health insurance benefits, many are turning to other practices that are increasing the number of uninsured people.

To remedy these problems we recommend that: (1) health insurance benefits be made personal and portable; (2) health insurance premiums be included in the gross wages of employees with tax credits for those premiums allowed on individual tax returns; (3) individual employees be given an opportunity to choose between lower wages and more health insurance coverage (or vice versa); and (4) individual employees be given freedom of choice among all health insurance policies sold in the marketplace.

If implemented, these recommendations would have five major advantages:

1. Rising health care costs would no longer be a problem for employers, since health insurance premiums would be a direct substitute for wages.
2. Employees would have opportunities to choose lower cost policies and higher take-home pay.
3. Employees would have the opportunity to select policies tailored to their individual and family needs.
4. Employees would be able to retain the tax advantages of the current system but avoid the waste inherent in collectivized benefits.
5. Employees would be able to continue coverage at actuarially fair prices if they quit work or switched jobs.

When there is a direct link between salary and health insurance premiums, employees will be more prudent about the policy they choose. For example, those who want policies with no deductibles and all the bells and whistles will pay the full premium cost in the form of a salary reduction. Faced with this choice, employees are more likely to choose high-deductible, no-frills catastrophic coverage.[19]

7. Introducing Freedom of Information in the Hospital Marketplace

Because they lack access to the necessary information, individual patients often are unable to play an effective role in containing

[19]See Butler and Haislmaier, *A National Health System for America*, rev. ed., ch. 3.

hospital costs. In most American cities, patients cannot find out a hospital's total charge for a procedure prior to treatment. At the time of discharge, they learn there is not one price but hundreds of line item prices for everything from a single Tylenol capsule to the hospital's admission kit. After a patient has been in the hospital for only a few days, a typical bill can stretch many feet in length. If restaurants priced their services the way hospitals do, at the end of an evening meal customers would be charged for each time they had used the salt shaker, taken a pat of butter, and had their water glass refilled. There would, however, be this difference: at least they could read the restaurant's bill.

About 90 percent of the items listed on a hospital bill are unreadable. In only a handful of cases can patients both recognize what service was rendered and judge whether the charge is reasonable. For example, $15 for a Tylenol capsule is common but clearly outrageous, as is $25 for an admission kit. In other cases, patients may recognize the service but have no idea whether they are being overcharged. What's a "reasonable" price for an x-ray, a complete blood count, or a urinalysis? The patient who tries to find out is in for another surprise. Prices for items such as these can vary as much as five to one among hospitals within walking distance of each other, and in most cases the prices charged bear no relationship to the real cost of providing the service.

Patients who try to find out about prices prior to admission face another surprise. A single hospital can have as many as 12,000 different line item prices. For example, for patients doing comparison shopping among the 50 hospitals in the Chicago area, there are as many as 600,000 prices to compare. To make matters worse, different hospitals frequently use different accounting systems. As a result, the definition of a service may differ from hospital to hospital.

Although hospital administrators do not have to give patients advance notice of their total bill, hospitals in Illinois are required to tell the state government. The following are some examples of total charges for outpatient services reported by Chicago hospitals in 1988: The charge for a mammogram varied from $13 to $127 (a difference of almost 10 to 1), the charge for a CAT scan varied from $59 to $635 (a difference of more than 10 to 1), tonsillectomy charges ranged from $125 to $3,365 (a difference of 27 to 1), and cataract

removal charges varied from $125 to $4,279 (a difference of 34 to 1).[20] If patients knew about these differences, they could significantly reduce their medical bills. Unfortunately, most do not.

Hospital prices today are an unfortunate remnant of the system of cost-plus hospital finance. Because 90 percent of hospital revenue came from insurers who reimbursed on the basis of costs, a hospital's line item prices were relevant only for a small fraction of the hospital's income—the 10 percent paid out-of-pocket by patients. Hospital line item prices were used in some of the more complicated cost-plus reimbursement formulas, however. This gave hospitals an incentive to manipulate third-party reimbursements through artificial pricing. Hospital prices quickly became artifacts rather than real prices determined by supply and demand.

We cannot possibly control spiraling health care costs unless patients can make prudent buying decisions. That cannot happen unless patients are given package prices prior to hospital admission. Accordingly, any hospital that receives Medicare money should be required to quote preadmission prices—either per procedure or per diem—to all patients.[21] This is a requirement to quote prices, not an attempt to create price controls. Hospitals would remain free to charge any price to any patient.

What do hospital managers say about quoting preadmission, package prices for surgery? That depends. Publicly, they say that such a system would not work because physicians cannot predict in advance what complications will arise (and therefore what costs will be) with respect to any particular patient's surgery. Privately, they are already quoting package prices to major third-party buyers of health care. In late 1990, for example, the St. Louis Area Business Coalition on Health formally and publicly requested the area's 40 hospitals to voluntarily submit their retail prices for 205 different patient services. There was apparently considerable controversy about the proposal and what it might portend for the future. In a follow-up survey of the heads of state hospital associations, 73

[20]Illinois Health Care Cost Containment Council, *A Report of Selected Prices at Illinois Hospitals: Outpatient Services* (August 1989).

[21]In some cases, for example exploratory surgery, a hospital might quote "not to exceed" prices.

percent of the respondents said they would oppose public disclosure of their retail prices.[22]

On the other hand, the practice of quoting preadmission prices is far more common than many people believe. In 1983, the federal government began paying fixed prices to hospitals for surgical procedures classified in one of 467 diagnosis-related groups (DRGs). Many states reimburse hospitals in a similar way through their Medicaid programs. Although hospital managers complain (justifiably, in many cases) that the DRG payments are too low, many hospitals voluntarily charge (higher) DRG prices or fixed per diem prices to large third-party payers. In Nebraska, for example, Blue Cross reimburses almost all hospitals based on prospective DRG rates.

A more radical move would be to combine the hospital charges with surgeons' fees and other charges into a single package price, covering all costs of surgery. A step in this direction was recently taken as part of a demonstration project undertaken by the Health Care Financing Administration, the organization that administers Medicare.[23] Medicare has contracted with four major hospitals to provide heart bypass surgery at fixed prices. When Medicare announced its intention to conduct this three-year project, more than 200 hospitals applied to participate. Although Medicare did not select hospitals on the basis of price, the agreed-upon prices are between 5 percent and 20 percent below the amount Medicare was paying when all of the components of the surgery were reimbursed separately.

The Medicare demonstration project is not unique. Individual hospitals and hospital groups are forming "centers of excellence" and bidding in a national market for the right to perform as many as 25 types of high-cost surgery. A Houston hospital, for example, has approached Blue Cross of Indiana with an offer to perform all of its bypass surgery for half of what Blue Cross would normally pay.[24] With some of the best heart surgeons in the country, the Houston hospital offers high-quality surgery at a price that often

[22]David Burda, "Many State Hospital Association Presidents Would Resist Efforts to Establish Price Lists," *Modern Healthcare,* January 28, 1991, p. 34.

[23]Hilary Stout, "Medicare Starts Experimental Program to Curb Costs of Heart Bypass Surgery," *Wall Street Journal,* January 31, 1991, p. B5.

[24]Authors' communication.

includes the patient's airfare, as well as airfare and room and board (at the hospital) for the patient's spouse.

The concept of a package price covering all services has been common for years in the field of cosmetic surgery. Similarly, some physicians or optometrists quote fixed prices for performing refractions and fitting contact lenses, and dentists often quote fixed prices for new dentures. Of course, the underlying variation in costs for these procedures is small, so the provider is not at great risk when charging a package price. But in at least a third of the DRG categories, the variation in costs is also quite small. For high-ticket items such as heart surgery, costs can vary a great deal. But the market is showing us that, when the volume for these types of surgery is high, many hospitals are willing to charge a package price and accept the risk.

8. Encouraging Savings for Postretirement Medical Expenses

One of the greatest social challenges we face as we move toward the next century is paying retirement pensions and medical expenses for the elderly. Because both Social Security and Medicare are pay-as-you-go programs in which there is no current saving to meet future obligations, tomorrow's obligations will have to be met mainly by taxes on tomorrow's workers. The bill will be high. According to reasonable projections (see chapter 13), by the year 2000, total health care expenses for the elderly will equal 14 percent of workers' payroll, and health care plus Social Security will equal 26 percent. By the year 2050, total health care spending for the elderly will equal 55 percent of payroll, and health care plus Social Security will equal 78 percent.[25]

Currently, the elderly pay about one-third of their own health care expenses. Even if we can continue that practice, the future burden on workers will be enormous. The combined burden of elderly health care and Social Security will be 21.5 percent of payroll by the year 2000, and could reach 60 percent of payroll by the year 2050.[26]

[25]These projections are based on assumptions used in the Social Security Administration's pessimistic projections. See John C. Goodman and Gerald L. Musgrave, *Health Care after Retirement,* NCPA Policy Report no. 139 (Dallas: National Center for Policy Analysis, June 1989), Table III (p. 6).

[26]Ibid.

Although the federal government subsidizes spending on current medical needs to the tune of $60 billion a year, individuals receive no tax subsidy when they save for postretirement medical needs.[27] Corporations also are greatly constrained by current tax law in their ability to set aside funds today for the postretirement health care expenses of their employees. As a result, the federal government is encouraging employers and employees to adopt the same pay-as-you-go approach that characterizes Medicare and other government health care programs for the elderly. Currently, unfunded liabilities for U.S. employers for postretirement health care exceed $300 billion. If these liabilities had been accounted for in 1989, they would have reduced corporate earnings of companies with postretirement health care liabilities by 33 percent—and their net worth by 30 percent.[28]

To address this problem, individuals and employers must be encouraged to save and invest today for future health care expenses. One method would be to use deposits to Medisave accounts, which would grow tax-free and provide funds for medical expenses (including nursing home care and long-term care insurance) not now covered by Medicare. More is needed, however.

Individuals and their employers should be given tax incentives to contribute to Medical IRA (MIRA) accounts. Funds deposited to MIRAs would substitute for future claims against Medicare. By making annual contributions over time, people would rely more on private savings to support their postretirement medical needs, and less on Medicare. Eventually, we would move to a postretirement health care system in which each generation pays its own way and in which postretirement health care dollars become the private property of the elderly, out of reach of politicians and special-interest bureaucracies (see chapter 15).[29]

[27]Jonathan C. Dopkeen, *Postretirement Health Benefits,* Pew Memorial Trust Policy Synthesis 2, Health Services Research 21, no. 6 (February 1987): 810.

[28]Mark J. Warshawsky, "Retiree Health Benefits: Promises Uncertain?" *The American Enterprise* (July/August 1991), p. 63. Corporations will be required to estimate their liabilities and account for them beginning in 1993. See discussion in chapter 13 of this book.

[29]In principle, there could be three types of deductible deposits to the same account: one for savings for current medical expenses, a second for funds to supplement Medicare during retirement, and a third to replace Medicare. Institutions that manage these accounts would keep separate balances for each of the three purposes.

9. Creating Catastrophic Health Insurance Coverage for the Elderly

The Medicare program pays too many small medical bills that the elderly could easily afford to pay out-of-pocket, but it leaves Medicare beneficiaries exposed to the risk of a catastrophic medical event, such as Alzheimer's disease, requiring an expensive nursing home stay. To address this problem, private insurers should be given the opportunity to repackage Medicare benefits and compete for customers based on the package of benefits they offer.

A major reason why Congress was unable in 1989 to solve the problem of catastrophic coverage for the elderly was the fact (as discussed in chapter 15) that Medicare is a one-size-fits-all insurance policy designed for a very diverse group. Because the elderly who have few assets would be on Medicaid anyway, they are less interested in a catastrophic health care bill than in coverage for small medical bills. The elderly who have substantial assets are capable of paying several thousand dollars of small medical bills each year, but do need catastrophic coverage.

Private health insurers should have the opportunity to repackage Medicare benefits by offering private policies as an alternative to Medicare. The only required benefit would be catastrophic hospital insurance. If an elderly person chose a private insurer, the insurer would receive 95 percent of the actuarially fair value of Medicare insurance. For example, a private insurer might offer Medicare beneficiaries a policy with a $2,000 hospital deductible, a $2,000 physician deductible, and a combined deductible of $3,000. In return for these higher deductibles, the insurer might offer immediate nursing home coverage for Alzheimer's disease and an expanding nursing home benefit for other illnesses, depending on the number of years of coverage.[30]

Currently Medicare offers the 95 percent option to health maintenance organizations (HMOs), provided that they cover all of the benefits prescribed by Medicare. The same offer should be open to other insurers, who would compete for patients, and HMOs and other insurers should be free to repackage the benefits in ways attractive to Medicare beneficiaries. No one should be forced to

[30]Under this proposal, private insurers could reimburse hospitals at Medicare's fixed DRG rates. They could also seek less expensive ways to deliver medical care. For a similar proposal, see Peter Ferrara, "Health Care and the Elderly," in Butler and Haislmaier, pp. 85–87.

participate, but these alternative plans could provide needed services, equity, and efficiency for the beneficiaries.

10. Empowering Medicaid and Medicare Patients

Medicare and Medicaid are price-fixing schemes in which the level of reimbursement is often too low to ensure high-quality health care. The result increasingly is implicit and sometimes explicit health care rationing. To deal with this problem, Medicare and Medicaid patients should have the right to circumvent the normal reimbursement rules in ways that empower them and make them full participants in the medical marketplace.

In virtually every state, the people who matter least in the construction of health care programs for the poor are poor people. Far from empowering the indigent, the health care poverty industry consists of relationships between large bureaucracies in which poor patients are an excuse for the transfers of large sums of money.

The Medicaid program in many states pays about half as much as other insurers for comparable services. In itself, such a practice is not bad. Medicaid patients may have to wait for a hospital bed in order to obtain elective surgery, but in return for waiting they receive free medical care. What is bad is that they have no input into the terms of the discount or the conditions of the surgery, and they have increasingly fewer options in the market for any medical service. The reason is that Medicaid patients are not the principal clients of the medical community; the Medicaid bureaucracy is. The type of medical service the patients receive is often dictated by the amount the bureaucracy will pay. Patients cannot add to this amount to purchase higher quality service.

Nationwide, "good" doctors increasingly will not see Medicaid patients, especially for prenatal care. Some who do see them often practice revolving door medicine in which the objective is to service patients—and submit Medicaid reimbursement forms—as quickly as possible. To make matters worse, state laws generally prohibit nurse practitioners and physicians' assistants (including people who gave medical care to our troops in Vietnam and the Persian Gulf) from providing low-income patients with primary care services. The result is a continuing deterioration in the quality of care that Medicaid patients receive. In some places, outright rationing schemes have been installed—schemes constructed by the health care bureaucracy, not by the patients themselves.

As an initial step toward empowering patients and dismantling the Medicaid bureaucracy, we should identify areas in which to suspend the normal reimbursement rules. Pregnant women on Medicaid, for example, should have an account to draw on for prenatal care. They should be able to add personal funds to this account, negotiate prices, and pay any amount they choose for prenatal care from any physician. They should also be allowed to share in any cost savings they achieve.

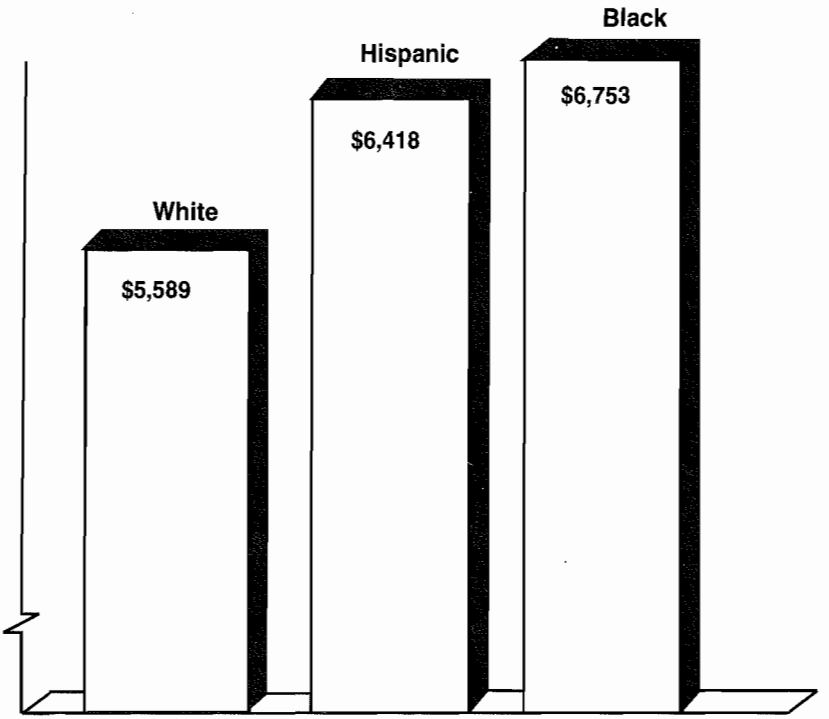
Similar reforms are needed under Medicare. Medicare's DRG system for reimbursing hospitals is not structured so that government is simply one more buyer in a competitive market. Instead, the system is a price-fixing scheme in which the government attempts to create an artificial market. Medicare literally fixes the price of services rendered, independent of supply and demand, forbidding hospitals to charge more than the DRG price even to patients willing to pay more. Medicare also prohibits hospitals from giving rebates to patients who use their services. Moreover, a single, national rate of reimbursement that ignores local differences is under consideration, and plans are also under way to include physicians' services in fixed DRG payments.[31]

Attempting to establish an artificial market creates perverse incentives for providers, which may adversely affect patients' health and may even increase health care costs. At the most basic level, in any price-fixing scheme the price can be set either too high or too low. If it's too high, the system encourages too many medical procedures, as was the case under pure cost-plus reimbursement. If it's too low, the system encourages too few.

In principle, the DRG price covers the average cost of treatment for hospitals that treat a wide variety of patients. But it is unlikely that any particular hospital will have an "average" case load. Clearly, survival in the hospital marketplace in this system means attracting below-average-cost patients and avoiding above-average-cost patients. Who are the high-cost patients? They are the sickest

[31]See Robert Pear, "Government Seeks New Cost Control on Medicare Plan," *New York Times*, June 9, 1991. Under a Health Care Financing Administration (HCFA) contract, 3M Health Information Systems developed 297 ambulatory patient groups similar to DRGs for inpatient services. The new regulations will probably become law in 1993. Current law requires the DRG system to be designed for the HCFA by October 1, 1991. See *Modern Healthcare*, June 24, 1991, p. 48.

Figure 3.5
HOSPITAL COST PER ADMISSION BY RACE*



SOURCE: Eric Muñoz et al., "Race, DRGs, and the Consumption of Hospital Resources," *Health Affairs* (Spring 1989), p. 187.

*Based on admissions to Long Island Jewish Medical Center during 1985–87. Adjusted for DRG weight index.

patients, and more often than not they are low-income and nonwhite. For example, blacks and Hispanics have more severe illnesses, longer hospital stays, and (as Figure 3.5 shows) higher hospital costs than white patients, on the average.[32]

There is increasing evidence that hospitals are responding to the financial initiatives created by the DRG system. Thus, they give care readily and quickly to the "profitable" Medicare patients, but

[32]Eric Muñoz et al., "Race, DRGs, and the Consumption of Hospital Resources," *Health Affairs* (Spring 1989), p. 187.

slowly, reluctantly, and often of a lesser quality to the "unprofitable" Medicare patients.

Another consequence of Medicare's method of payment is the rationing of medical technology. For example, although hearing loss is the most prevalent chronic disability among the elderly and affects almost one-third of all Medicare patients, Medicare's reimbursement rate for cochlear implants is so low that only a handful of Medicare patients have received the treatment.[33] Of about 68,000 Medicare beneficiaries who could benefit from the device, only 69 have received it under Medicare reimbursement—which makes each patient's odds of receiving the device only about 1 in 1,000. Currently, the cost of the operation plus the device is between $25,000 and $35,000. But, on the average, Medicare reimburses only $10,500,[34] so that the hospital loses between $14,500 and $24,500 on each case. Medicare forbids patients from making up the loss to the hospital with their own funds. The result is that the technology is virtually rationed out of existence. Rather than being an anomaly, this Medicare financing strategy is likely to become the standard practice in the future.

The recommendations made here are only partial steps toward a more complete reform of the Medicaid and Medicare programs. The ultimate goal should be to allow the beneficiaries to negotiate all prices in a market in which they, rather than third-party bureaucracies, are the principal buyers of health care. We should continue to limit the amount that taxpayers pay. But we should allow the market to determine the price and quality of health care.

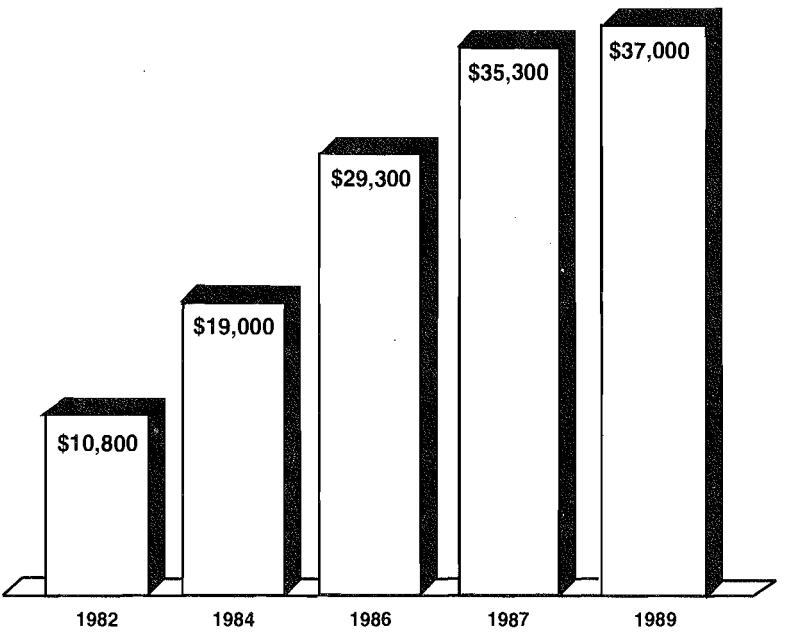
11. Avoiding the Costs of the Tort System

No one knows how much the tort liability system adds to an average medical bill. Most people think the number is quite large. Apart from measurable items (such as attorneys' fees, court costs, damage awards, and settlement checks), there are thousands of unseen ways in which the tort system affects costs. Out of fear that adverse medical events will trigger a lawsuit, for example,

[33]Nancy M. Kane and Paul D. Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," *New England Journal of Medicine* 321, no. 21 (November 16, 1989): 1380.

[34]"Proposed Rate for Prospective Payment of Cochlear Implantation," *Government Affairs Review* (September/October 1990), p. 7.

Figure 3.6
AVERAGE ANNUAL MALPRACTICE PREMIUMS FOR OBSTETRICIANS



SOURCE: Martin L. Gonzales, ed., *Socioeconomic Characteristics of Medical Practice* (Chicago: American Medical Association, 1991), Table 55, p. 147.

physicians order extra tests, perform extra procedures, and otherwise practice defensive medicine. The American Medical Association's Center for Health Policy Research estimates that physicians spent $4.2 billion on malpractice insurance premiums in 1989 and $12.8 billion more on defensive medicine, for a total of $17 billion. Other estimates place the number even higher.[35] As Figure 3.6 shows, insurance premiums for obstetricians soared during the 1980s and are much higher in areas where lawsuits are more likely. Obstetricians in New York's Nassau and Suffolk counties pay about

[35]See Peter W. Huber, *Liability: The Legal Revolution and Its Consequences* (New York: Basic Books, 1988).

$100,000 a year and obstetricians in southern Florida pay $200,000.[36] These costs ultimately are borne by patients and their insurers.

The tort system is not all bad. In an environment in which third-party payers pressure providers to reduce the quality of health care, the tort system may be the single most important protector of patient welfare. By contrast, consider a country such as Britain, where the quality-reducing pressures are much greater and the rights of plaintiffs much more restricted. When British patients sue hospitals, they are actually suing the government. Unquestionably, there is far more actual malpractice in Britain than in the United States.[37]

The primary problem with the U.S. tort system is that it is another bureaucracy, replete with its own set of perverse incentives. Moreover, it feeds off the health care sector with little consideration of the damage done to others. Juries do not even know (nor are they allowed to consider) that when they give a $5 million damage award, the precedent from that decision affects every other patient, physician, and hospital—not just the litigants in the specific case. To make matters worse, it is impossible to avoid the system by voluntary contract. For example, one sensible way to cut down on the litigation costs for simple negligence would be to have the hospital take out a life insurance policy on a patient prior to surgery. The hospital and the patient (or the patient's family) could agree that if the patient dies for any reason, the beneficiaries will accept the policy's payment as full compensation, even if there was negligence. The same principle could apply to other injuries, such as a disability leading to a loss of income. Litigation costs would be avoided, and life insurance companies would have incentives to monitor the quality of hospital care. But the current tort system does not permit such arrangements.[38]

Not only can patients and medical providers not get around the inefficiencies of the tort system by voluntary agreement, but the

[36]Milt Freudenheim, "Costs of Medical Malpractice Drop after an 11-Year Climb," *New York Times*, June 11, 1989.

[37]See John C. Goodman, *National Health Care in Great Britain: Lessons for the USA* (Dallas: Fisher Institute, 1980): 121–2.

[38]More precisely, the current system ignores contractual waivers of tort liability claims. What is needed is a legal change requiring the courts to honor certain types of contracts under which tort claims are waived in return for compensation.

tort system introduces a new set of perverse incentives that can be harmful to patients. Fear of tort liability is a strong incentive for medical providers to withhold and conceal information that is vitally important to patients. Most proposals to solve this problem would place arbitrary limits on the rights of plaintiffs in malpractice suits. Such proposals, while not all bad, attempt to solve problems by bureaucratic fiat rather than by voluntary exchanges that are mutually beneficial to both patients and providers. A more direct solution would be to give patients the right to make contractual agreements in their own interests. Patients should have the same rights as buyers in other markets, including the right to waive certain tort claims in return for reductions in the cost of services or for other monetary compensation.

12. Creating Medical Enterprise Zones

There are 111 rural counties in the United States that have no physician. About half a million rural people live in counties with no physician trained to provide obstetric care, and 49 million live in counties with no psychiatrist. Although hospitals are closing in most parts of the country, rural hospitals have been closing at twice the rate of urban hospitals.[39]

Many people assume that the only way to meet the health care needs of rural citizens is to spend more government money on rural health care programs. In fact, current government programs and policies are probably a far greater obstacle to good quality care at a reasonable price than is lack of funds.

As noted above, in most states, medics who treated soldiers in the field in the Vietnam War or the Persian Gulf War are not allowed to treat ordinary citizens, even if no doctor lives in the area. The same restrictions apply to nurses and physicians' assistants, despite studies showing that paramedical personnel can deliver certain kinds of primary care as well as—and sometimes better than—licensed physicians (see chapter 5).[40]

Many state and federal regulations discriminate against rural areas in other ways. For example, Medicare rules require rural hospitals to maintain a staff of numerous professionals (whether

[39]For a survey of health care problems in rural areas, see U.S. Office of Technology Assessment, *Health Care in Rural America* (Washington: September 1990).

[40]See the discussion in chapter 5.

needed or not), including a full-time director of food and dietary services. State licensing laws often require rural hospitals to have fully equipped operating rooms and a surgical staff—even if the hospital performs no surgery.[41] These cost-increasing regulations may make sense in large urban areas, but in rural areas they often cause existing facilities to close and prevent new facilities from opening.

The concept behind Medical Enterprise Zones (MEZs) is that underserved areas should have the freedom and flexibility to make their own decisions about the best way to meet health care needs with scarce resources. Accordingly, within MEZs, many of the normal restrictive rules and regulations would be suspended, thereby creating new options and opportunities for people who live there. (The concept of the MEZ and its applicability to rural health care are examined more fully in chapter 20.)

Closely related to the MEZ is the concept of a Medical Enterprise Program (MEP). Whereas an MEZ is defined in terms of a geographical area, an MEP is defined in terms of a market being served. The urban poor often face many of the same problems as residents of rural areas—not because of a lack of physicians and facilities, but because they have been priced out of the market by government regulations that are often the result of special-interest pressures. Accordingly, people who are primarily providing medical services to low-income families should be allowed to participate in MEPs. MEP providers and MEP facilities would be permitted to avoid many government regulations in much the same way those in MEZs do.

13. Restoring the Safety Net by Empowering Local Communities

One of the most critical sources of waste in our health care system is the set of rules and regulations governing the spending of public health care dollars. Politicians in Washington and in state capitals—far removed from the day-to-day, problem-solving activities of local communities—dictate who is eligible for aid and the terms and conditions under which medical care can be delivered. In doing so,

[41]For a more comprehensive list of cost-increasing regulations that discriminate against rural health care facilities, see U.S. Office of Technology Assessment, pp. 181–93.

they tie the hands of local citizens and prevent them from efficiently using limited resources to meet health care needs.

We have already seen how the Medicaid program serves poorly (and inefficiently) the needs of poor, pregnant women. Almost anyone involved in indigent health care in the United States can point to hundreds of other examples. For example, largely because of regulations and special-interest political pressures, about one-third of all Medicaid dollars are spent on the elderly, even though only one in eight beneficiaries is elderly and even though the elderly have about the lowest poverty rate of any population age group. Furthermore, it is federal law—not the preferences of local communities—that dictates that an elderly chronic patient must be treated in an expensive nursing facility (at a cost as high as $60,000 per year) rather than in a home (at a cost of $15,000). A better solution would be simply to give Medicaid funds to local communities, unrestricted except for the requirement that the money be spent on indigent health care. The decisions about how much aid to give, and to whom, would then be made by people best able to judge the needs, resources, and alternatives, which vary considerably from area to area.

A more radical solution would be to turn all means-tested welfare dollars (including food stamps, housing, etc.) over to local communities. The argument for doing so is compelling. Considering that the nation is spending $500 million in hospital costs to treat cocaine babies,[42] should some of the money now being spent on treatment be used to prevent the problem from arising in the first place? Local people dealing directly with the problem are likely to arrive at better answers to that question than politicians in Washington. If local communities, rather than the federal or state governments, controlled the $200 billion plus that we now spend each year on means-tested welfare programs, there would be considerable experimentation and innovation. Local communities would learn much through trial and error and from each other. In some communities (the District of Columbia comes to mind), the results might be worse than what we have now. But in the vast majority of cases we could

[42]Ciaran S. Phibbs, David A. Bateman, et al., "The Neonatal Costs of Maternal Cocaine Use," *Journal of the American Medical Association* 266, no. 11 (September 18, 1991): 1521–6.

expect a considerable improvement over the current welfare state. (These and similar ideas are developed more fully in chapter 20.)

14. Creating the Right Kind of Play-or-Pay Plan

In what way does government have a legitimate interest in whether people with the means to do so buy health insurance? The standard argument is that, if people are free to choose as individuals, some (perhaps many) will choose not to be insured. If they have a catastrophic illness, however, many of those uninsured people will be unable to pay the full costs—thus creating a financial burden for the rest of us. It follows that it is a matter of financial self-protection for the majority of people who have health insurance to insist that everyone else purchase it as well.

This argument has persuaded "conservative" organizations, such as the Heritage Foundation[43] and the American Enterprise Institute,[44] to propose laws requiring everyone to purchase health insurance whether they want to or not. Many "liberal" groups pursue the same goal but with more deception—they would force employers to purchase health insurance for their employees. Because virtually all economists agree that fringe benefits such as health insurance are a substitute for wages, employer mandates are nothing more than disguised employee mandates, and the cost would come out of the pockets of workers. As an alternative to direct employer mandates, some propose a play-or-pay option: People would either have to purchase health insurance or pay a tax in return for government-provided health insurance.

Almost all plans for mandating health insurance would impose a tax on labor, leading to less work, fewer jobs, and an expensive burden for those who work in the small-business sector, which is the job-creating sector of the economy (see chapter 12). In addition, once health insurance is mandated, an immediate constituency is created to pressure government to control the costs. Mandating

[43]The Heritage Foundation plan is presented in Butler and Haislmaier, *A National Health System for America*.

[44]The American Enterprise Institute proposal is presented in Mark Pauly et al., "A Plan for 'Responsible National Health Insurance'," *Health Affairs* (Spring 1991), pp. 5–25.

health insurance is an open invitation to government to step in and regulate the entire health care system (see chapter 6).[45]

Fortunately, there is a better way. If the proposals made above were adopted, every American would face a choice: buy subsidized health insurance or pay higher taxes. The extra taxes paid by those who choose to be uninsured should go into a special fund and be returned to local hospitals that provide free care to indigent patients. Of course, free care is not likely to be as desirable as purchased care and may involve considerable health care rationing. Moreover, those who receive free care will still be personally liable for their health care costs and may be forced into bankruptcy. Thus, while providing a mechanism for paying for health care for the uninsured, this proposal retains financial and other incentives for people to purchase health insurance.

If people who chose not to purchase health insurance paid higher taxes, would those extra taxes be enough to pay the unpaid health bills they generate? That's not clear. But there are reasons to think that they might be. People who do not have health insurance today are not really getting a free ride (see chapter 20). Because they do not receive employer-subsidized health insurance, they pay higher taxes. And based on the average tax subsidy received by those who have employer-provided health insurance, the higher taxes paid by the uninsured are about equal to the amount of unpaid hospital bills they generate.

What is unfair about the current system is not that uninsured people are not paying their own way; it is that, unlike most people with health insurance, most people without it never get an opportunity to purchase it at a tax-subsidized price.

15. *Employing a Cost-Benefit Standard for Health and Safety Regulatory Agencies*

There is probably no single source of waste in our health care system that can compare to the routine amount of waste generated by federal regulatory agencies, including the Occupational Safety

[45]A play-or-pay plan endorsed by leading Senate Democrats (discussed in chapter 12) hints that sweeping federal regulation may be necessary. A plan proposed by House Ways and Means Committee chairman, Dan Rostenkowski (D-IL), accepts regulation as inevitable and proposes a mechanism for instituting it.

and Health Administration (OSHA) and the Environmental Protection Agency (EPA). In most calculations, the amounts spent and the costs imposed on the private sector by OSHA and the EPA are not included in the nation's annual health care bill. But a significant amount of the activities of both agencies is just as much a health care expenditure as is a physician's fee.

For example, the air toxics section of the recently amended Clean Air Act has only one real goal: to reduce cancer. Accordingly, it is fully comparable to any other expense designed to prevent or cure cancer. How well does the EPA perform as a cancer-preventing agency? Despite the fact that industrial products and food additives cause less than 3 percent of all cancers,[46] the federal government is imposing billions of dollars of costs on the American public in its efforts to prevent exposure to trace amounts of chemicals in our environment.[47] The most common government standard is that a chemical should be outlawed if one person out of one million exposed over a lifetime could theoretically get cancer from it. Even though 300,000 people out of one million will get cancer anyway, regulations cost the public billions of dollars to prevent the theoretical death of one more.

Typical EPA methods for evaluating the public health risks from air pollution greatly overstate those risks. For example, the EPA calculates potential risks from exposure to an air pollutant by testing the chemical for toxicity in laboratory animals. The chemical is administered to rats and mice in massive daily doses just below the amount that would kill them immediately. At such high levels of exposure, one out of every two chemicals ever tested (both natural

[46]A study by Oxford University professors Richard Doll and Richard Peto, commissioned by the U.S. Office of Technology Assessment, examined U.S. national cancer mortality records from 1933 to 1978 and found that only approximately 2 percent of all cancers are caused by environmental contamination or pollution. See Doll and Peto, "The Causes of Cancer: Quantitative Estimates of Avoidable Risks of Cancer in the United States Today," *Journal of the National Cancer Institute* 66, no. 6 (1981): 1191–308. The EPA's own findings, based on the use of toxicological risk assessment, corroborate Doll and Peto's analysis. According to the EPA, only between 1 and 3 percent of all cancers are caused by "pollution." See EPA, *Unfinished Business*. The EPA figures were extrapolated in Michael Gough, "Estimating Cancer Mortality," *Environmental Science & Technology* (August 1989), p. 925.

[47]See Frederick Rueter and Wilbur Steger, "Air Toxics and Public Health," *Regulation* (Winter 1990).

and man-made) eventually causes cancer in at least one species of rodent. The EPA then extrapolates from rodents to humans and estimates the human risk of cancer from exposure to the same chemical.

Scientists are increasingly skeptical about the value of extrapolating from these rodent experiments the risk to humans from ordinary exposure. Many are also skeptical about what the EPA does next. To calculate the risk to human populations, the EPA postulates an imaginary "Most Exposed Individual" (MEI), who lives on the property line of the emissions source and breathes the highest level of emissions from that source for 70 years, 24 hours each day. The EPA then assumes that everyone is an MEI.[48] Even with these pessimistic assumptions, the EPA estimates that only 1,700 to 2,700 cancers are caused each year by exposure to approximately 90 potentially hazardous air pollutants. Although that hypothetical number may seem large, it is a small fraction of the almost one million cancer cases that occur each year in America.[49] By some estimates, the air toxics section of the amended Clean Air Act will cost from $20 billion to $30 billion—about 10 to 15 times the entire annual budget of the National Cancer Institute. But because the regulations target only the largest polluters, the maximum reduction in cancer cases is likely to be 350 to 500 per year. That represents a cost of between $40 million and $86 million per cancer avoided.[50]

The EPA's extreme-risk models are notoriously faulty, however. A study of the largest concentration of industrial coke ovens in the country (Allegheny County, Pennsylvania) concludes that the EPA's estimate of cancer caused by coke emissions is exaggerated by a multiple of 100.[51] By the EPA's own calculations, its regulations on coke emissions cost $6.8 million per cancer prevented. Based on

[48]The EPA's high estimates of risk are generally hidden behind the large probability that any given individual will develop some type of cancer. However, its method of calculation so exaggerates risk that in at least one case (a Texaco plant at Port Neches, Texas) the EPA estimated that the added risk of cancer from living near the plant was one in ten. This is such a high figure that it should show up in public health figures. The EPA tries to avoid direct contradiction by arguing that these risk estimates should be used only for purposes of comparing relative risks.

[49]Rueter and Steger.

[50]"Air Toxic Madness," *Executive Alert* 4, no. 3 (May/June 1990): 5.

[51]Rueter and Steger.

more realistic calculations, the cost is $682 million to prevent a single instance of cancer.

The EPA's cost-is-no-object approach is also reflected in its new benzene regulations, which impose a cost of $200 million a year to prevent an EPA-estimated 3.4 cases of cancer.[52] By the EPA's own calculations, its new benzene regulations will cost $59 million to prevent a single instance of cancer. By more realistic calculations, the cost of each cancer prevented will be $5.8 billion.

Applying a more realistic method to all air toxics, it appears that the Clean Air Act's new air toxic regulations may prevent three to five cancers per year rather than 350 to 500. The cost per cancer prevented will be between $4 billion and $9 billion per year. (See Figure 3.7.)

The examples given above are by no means the most wasteful ones. Researchers at the Office of Management and Budget have calculated that some EPA regulations cost as much as $5.7 trillion per (expected, hypothetical) life saved.[53] This implies that the EPA is willing to spend the entire gross national product to save a single life. Clearly, scarce dollars designed to promote health are much better spent in areas in which the return promises to be much higher. Indeed, it is time to rethink the federal government's approach to preventing a great many diseases, including cancer.

About one in every three Americans will get cancer. About one in five will die from it. What should be done? An executive of the EPA says that the most effective way to combat cancer would be to give the entire EPA budget to the American Cancer Society. The National Cancer Institute's goal is to reduce the nation's 470,000 annual cancer deaths by one-half by the year 2000. Yet the institute does not even mention reducing carcinogenic chemicals in the environment as one of its objectives.

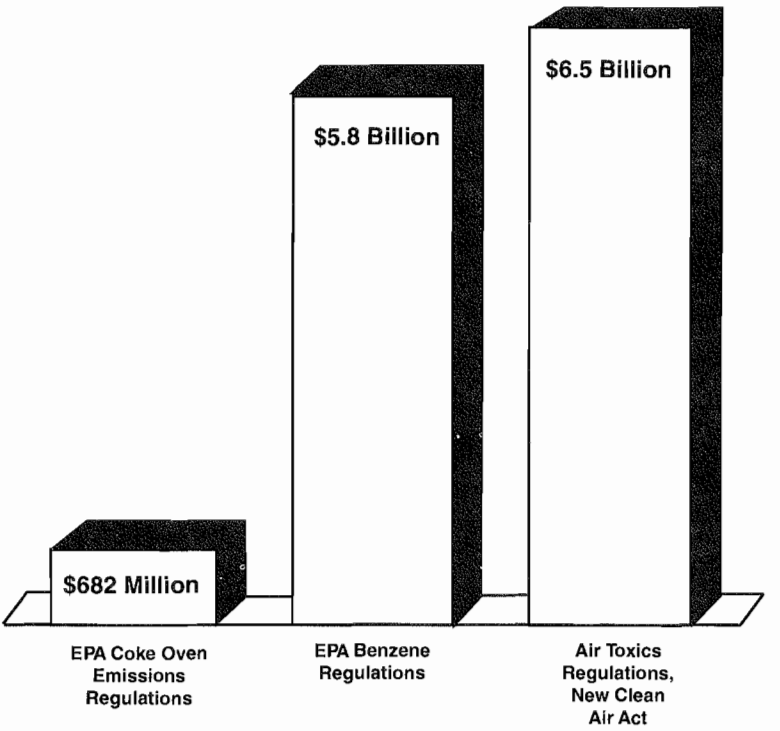
Consequences of Change

Adoption of the proposals made in this chapter would not immediately solve America's health care problems. But they would empower individuals, and create market institutions through which problems eventually would be solved by people pursuing their own

[52]Ibid.

[53]Private communication with the authors.

Figure 3.7
COST OF PREVENTING A SINGLE CANCER



SOURCE: Task Force Report, *Progressive Environmentalism*, NCPA Policy Report no. 162 (Dallas: National Center for Policy Analysis, April 1991).

self-interest. They would give individuals the incentive to solve problems that can never be solved through bureaucracies, regulations, or the power of government. The implementation of these proposals would constitute a national commitment to follow a path that is distinctly American in character—one that relies on individual choice and the efficiency of free markets.

4. Using the Agenda to Solve Problems

In chapter 2, we presented two conflicting visions of the health care system. This chapter will show how the two visions influence the health care debate. In general, the vision of the health care system that we accept determines what we think is possible and desirable, what we consider to be problems, how we analyze those problems, and how we propose to solve them. In the cost-plus vision, which has dominated thinking about health care in the United States since the end of World War II, the primary relationships are between bureaucracies rather than between individual patients and physicians. People who accept this vision inevitably attempt to solve health care problems through bureaucratic rule making or by changing the ways in which bureaucracies relate to each other. The other vision is of what we have called the ideal health care system, a system under which problems would be solved by relying on the power of competitive markets and the self-interested behavior of individuals.

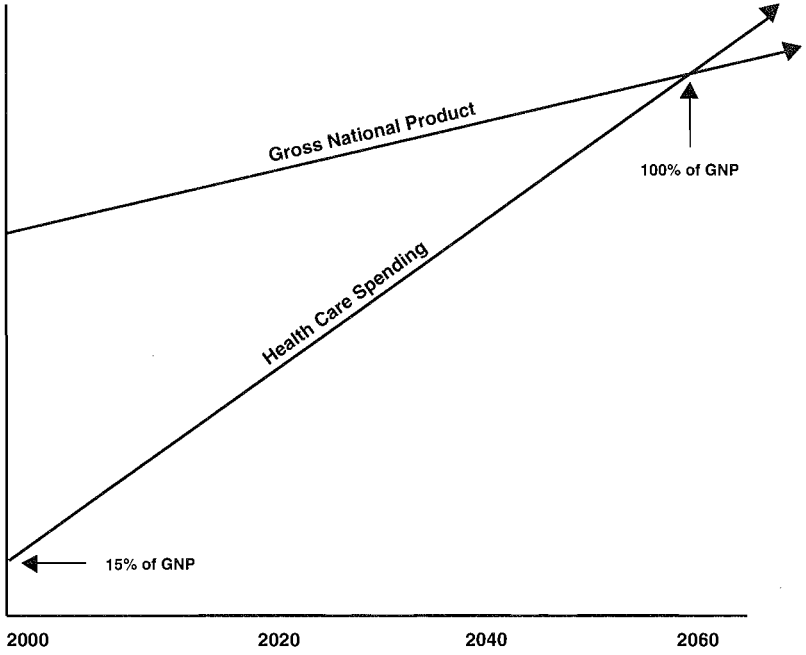
Twenty Major Social Problems and Their Solutions

We now turn to 20 major social problems that are said to exist in the U.S. health care system. Our goal is neither to provide a complete elaboration of the problems, nor to construct detailed solutions for them (many are discussed at length in later chapters). Rather, our goal is to sketch the nature of the problems and to show how the approach to solving them is critically dependent on one's vision of how the health care system should operate.

1. Rising Health Care Costs

The rate of increase in America's health care spending is a serious social problem. Over the past two decades, this rate has been twice the rate of increase of the gross national product (GNP). If this trend

Figure 4.1
TRENDS IN HEALTH CARE SPENDING AND GNP

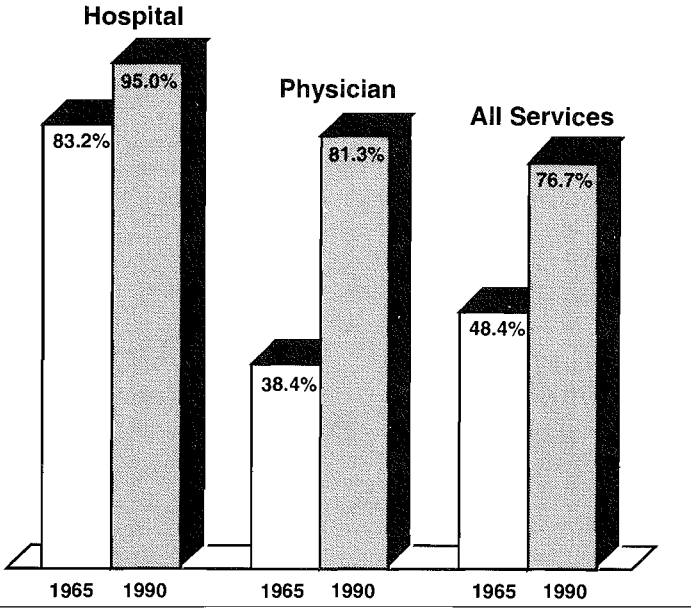


continues, we could be spending our entire GNP on health care by the year 2062.[1] (See Figure 4.1.)

The major reason costs are rising is that when patients and physicians get together, they are spending someone else's money rather than their own. In the hospital sector today, 95 percent of expenses are paid for by someone other than the patient, and as Figure 4.2 shows, since 1965 there has been a dramatic increase in the share of medical bills paid by third parties for every category of medical services. The share of physicians' fees paid by third parties, for example, has more than doubled, rising from 38.4 percent in 1965 to 81.3 percent in 1990. Moreover, the numbers in Figure 4.2 are averages; for many people, the extent of health insurance coverage is much greater.

[1]Projection based on data from the Health Care Financing Administration, Office of the Actuary.

Figure 4.2
PERCENT OF PERSONAL HEALTH EXPENSES PAID BY THIRD PARTIES, 1965 AND 1990



SOURCE: Health Care Financing Administration, Office of the Actuary.

One consequence of the rise in third-party payment of medical bills is that most people have no idea how much they are personally contributing to cover the nation's health care costs. As Table 4.1 shows, in 1992 we will spend about 12.9 percent of our GNP on health care, an amount equal to $8,000 for every U.S. household. This $8,000 burden is largely disguised, however. For a working-age family, the visible outlays are $1,580 for out-of-pocket expenses and $590 for payment for employer-provided health insurance.[2] For the nation as a whole, such visible expenses amount to only 3.6 percent of GNP. Because the remainder of the $8,000 burden is hidden in taxes and reduced wages, there is a universal illusion that health care costs are being paid by someone else.

A related illusion is that most people cannot afford to pay for health care. In fact, they are already affording it. As Table 4.1

[2]These amounts are net of government tax subsidies.

Table 4.1
HOW WE PAY FOR HEALTH CARE[1]

Method of Payment	Average per Household[2]	Percent of GNP	Percent of Personal Income	Percent of Money Income
Paid indirectly				
Medicare payroll taxes	$ 860	1.4%	1.6%	2.1%
Other federal, state, and local taxes[3]	3,070	4.9	5.8	7.4
Reduced wages—(employer-provided insurance)[4]	1,580	2.5	3.0	3.8
Other[5]	190	0.3	0.4	0.5
Paid directly				
Private health insurance premiums[6]	590	0.9	1.1	1.4
Out-of-pocket payments	1,580	2.5	3.0	3.8
Medicare premiums	130	0.2	0.2	0.3
Total	$8,000	12.9%	15.1%	19.4%

SOURCE: C. Eugene Steuerle, "Finance-Based Reform: The Search for an Adaptable Health Policy," paper presented at an American Enterprise Institute conference, "American Health Policy," Washington, October 3–4, 1991.

NOTE: Columns may not add to totals due to rounding.

[1]Based on estimated total health care spending for fiscal year 1992. Estimates are based on mean GNP per household of $62,160; mean personal income per household of $53,130; and mean money income per household of $41,320.

[2]Average household size in the United States was 2.63 persons in 1990. Amounts rounded to nearest $10.

[3]Includes taxes needed to finance direct government health spending out of general revenues, plus the amount that general taxes must be raised to compensate for revenue lost owing to special tax treatment of certain health-related income (about 26% of total).

[4]Employer contributions for health insurance, less government tax subsidies.

[5]Nonpatient revenue for the health care industry, including charitable donations, interest income, hospital parking, and gift shops.

[6]Includes employee contributions to private group health insurance plans, as well as individual policy premiums.

shows, 12.9 percent of GNP is equal to almost 20 percent of the average household's money income. Most families probably would claim that they could not possibly spend 20 percent of their income on health care. They would be shocked to learn that they are already spending that much.

How much should we as a nation spend on health care? Many people believe that health care spending should be determined by medical needs. Yet, if we followed the practice of spending health care dollars whenever a need was being met (or a medical benefit created), we could easily spend our entire GNP on health care. In fact, we could probably spend half of the entire GNP on diagnostic tests alone. Medical science has identified, for example, at least 900 tests that can be done on blood.[3] But for the inconvenience, why not make all 900 part of our annual checkup? Similarly, an annual checkup could include a brain scan, a full body scan, and numerous other tests.

As an example of how the demand for the services of primary care physicians could soar, consider the trade-off between the self-administration of nonprescription drugs and the use of physicians' services. In any given year, there are about 472 million office visits to primary care physicians. But economist Simon Rottenberg estimates that, if only 2 percent of nonprescription drug consumers chose professional care rather than self-medication, the number of patient visits would climb to 721 million, thereby requiring a 50 percent increase in the number of primary care physicians. If every user of nonprescription drugs sought professional care instead, we would need 25 times the current number of primary care physicians.[4]

More diagnostic tests and increased physicians' visits are just the beginning. Once we discover something really wrong, there is almost no limit to what medical science will eventually be able to do. We are reaching a point where we can replace virtually every joint and organ, including hips, elbows, heart, and lungs, and even eyes and ears. And, like those of the bionic man, the replacements

[3]Glenn Ruffenbach, "Medical Tests Go under the Microscope," *Wall Street Journal*, February 7, 1989. The University of Michigan Medical Laboratories perform, in house, approximately 900 different tests on blood. Other tests can be performed, but they are so rare that they are sent to private reference laboratories.

[4]Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation* 13, no. 2 (Summer 1990): 27–28.

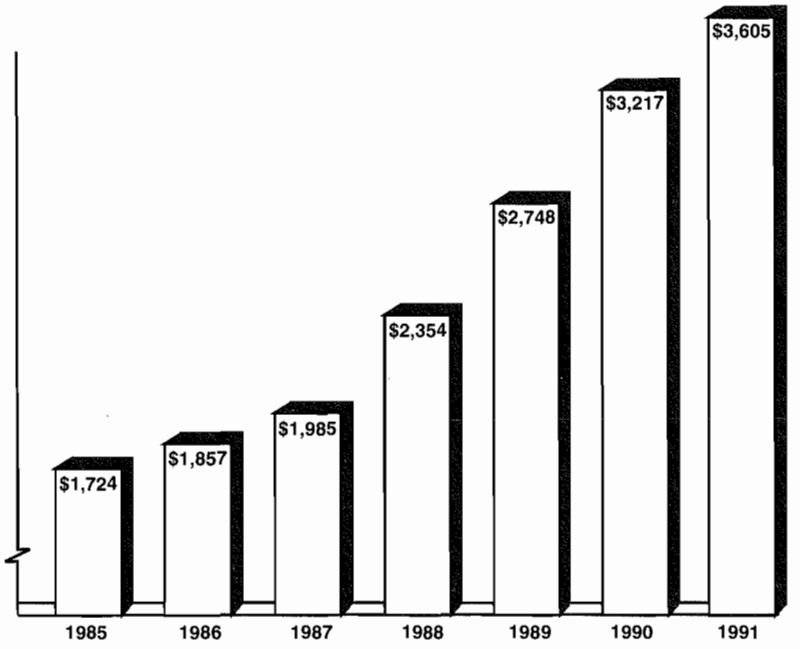
are often better than the originals. If someone else pays the bill, our potential demand for medical care could consume many times the nation's GNP, even today.

Proposals in the Cost-Plus Health Care System. From the bureaucratic perspective, some of the most commonly proposed solutions are to pass laws regulating hospital prices; pass laws limiting the number of hospital beds and the amount of hospital equipment; implement full-scale health care rationing; and nationalize the entire health care system and turn the problems over to the government. Each of these solutions would widen the gap between institutional rule making and the day-to-day practice of medicine. Far from eliminating perverse incentives, they would create even more. Individuals in the medical marketplace would still find it in their self-interest to spend other people's money while bureaucracies would attempt to block the pursuit of self-interest with more rules and regulations. The government-run health care systems of other countries are not more efficient than our own (as explained in chapter 17), and the governments in most of those countries are attempting to keep spending down by limiting hospital budgets. That usually means doing so by denying people medical care.

Solutions in the Ideal Health Care System. Health care costs cannot be controlled unless we empower individuals and make it in their self-interest to become prudent buyers of health care. When individuals have control of their own health care dollars through medical savings accounts, Medical IRAs (MIRAs), and health insurance reimbursements, they won't buy unless the services are worth the price. Most of us have no idea what percent of GNP is spent on orange juice or shoes. Because the people buying those products are spending their own money, not ours, we have no reason to care. In general, there is no right amount of money to spend on health care. The right amount is whatever people choose to spend, providing they are spending their own money and are facing prices that reflect the real social costs of medical services.

Controlling health care costs also means creating new incentives for the suppliers of services. In a competitive medical marketplace, suppliers would find it in their self-interest to lower price and improve quality and to communicate with potential buyers about price and quality.

Figure 4.3
TOTAL ANNUAL HEALTH CARE COSTS PER EMPLOYEE, 1985 TO 1991



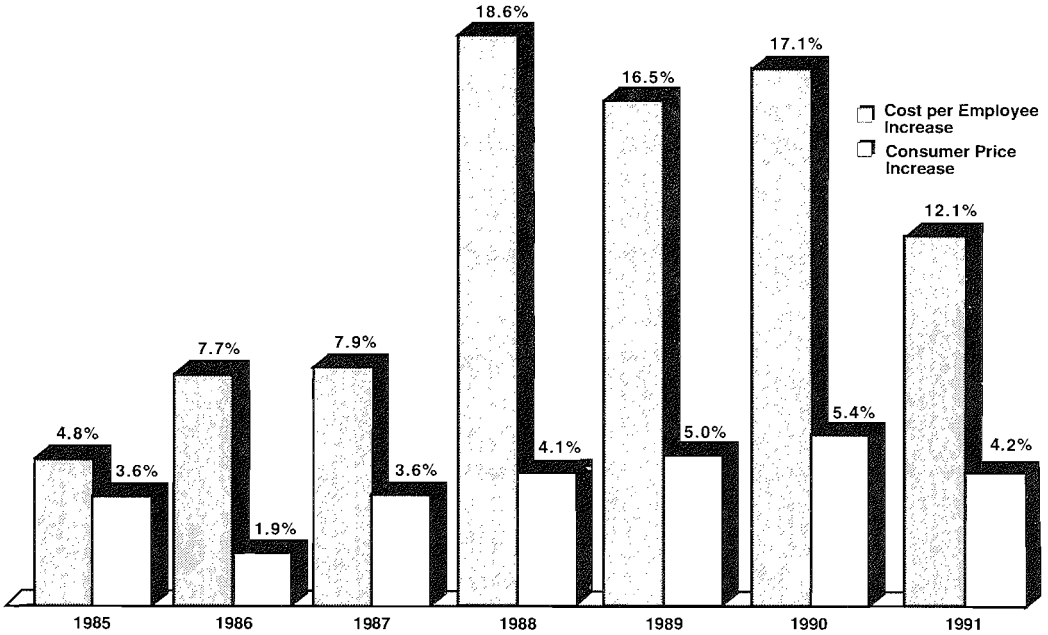
SOURCE: A. Foster Higgins & Co., *Health Care Benefits Survey, 1991: Indemnity Plans: Cost, Design and Funding.*

2. *Controlling Costs in Employer-Provided Health Insurance Plans*

As Figure 4.3 shows, between 1985 and 1991, the amount that employers spent annually on health care for each employee (and dependents) climbed from $1,724 to $3,605, an increase of 100 percent.[5] As Figure 4.4 shows, health care costs for employers have been increasing at about three times the rate of inflation and, in recent years, we have witnessed double-digit increases. Even the most profitable corporations cannot sustain increases in that range for long. It would be a mistake, however, to conclude that these

[5]A. Foster Higgins & Co., *Health Care Benefits Survey, 1990: Indemnity Plans: Cost, Design and Funding.*

Figure 4.4
ANNUAL PERCENT INCREASE IN HEALTH CARE COSTS PER EMPLOYEE, 1985 TO 1991



SOURCES: A. Foster Higgins & Co., *Health Care Benefits Survey, 1991: Indemnity Plans: Cost, Design and Funding;* and U.S. Bureau of Labor Statistics.

costs are ultimately borne by firms. Health insurance is a fringe benefit that substitutes for wages. Ultimately, therefore, the cost of wasteful health insurance comes out of the pockets of workers, not their employers.[6]

Proposals in the Cost-Plus Health Care System. For those who seek bureaucratic solutions, the proposals run the gamut: for example, make special deals with certain hospitals and require all employees to use only those hospitals, negotiate similar contracts with selected physicians, eliminate benefits from the company's health insurance policy, require corporate approval prior to major surgery, etc. Each of these proposals, however, further intrudes on the doctor/patient relationship. And each new set of rules expands the system's perverse incentives. These solutions operate within a framework in which the self-interest of employees and their physicians is diametrically opposed to the goals of the employer and/or the health insurance carrier. To appreciate the impact of this dichotomy, consider that two-thirds of the physicians in a 1989 poll indicated a willingness to help patients get health insurance benefits by misrepresenting a test as being "diagnostic" rather than for "general screening."[7]

Solutions in the Ideal Health Care System. If health insurance were individualized, and if employee patients controlled their own health care dollars, there would no longer be a corporate problem. The role of the employer would be to help negotiate good deals for employees or to help them choose a policy wisely. Each employee would choose a package of benefits tailored to individual and family needs. Cost-control devices, if needed, would be chosen voluntarily, not imposed from above. Moreover, for each individual employee, health insurance premiums would become a dollar-for-dollar substitute for wages. In the ideal health care system, employers would not attempt to force employees to do what was not in

[6]Automobile industry executives have often said that health insurance for auto workers adds $700 to $800 to the price of every new car. For example, see Lynn Wagner, "Business Agitates for Health System Revamp," *Modern Healthcare*, November 24, 1989, pp. 16–19. In fact, health insurance premiums add nothing to the price of cars. The $700 to $800 in premiums comes at the expense of higher wages for auto workers.

[7]John C. Pezullo et al., "Physicians' Attitudes towards Using Deception to Resolve Difficult Ethical Problems," *Journal of the American Medical Association* 261, no. 20 (May 26, 1989): 2980–85.

their self-interest in the medical marketplace. The only relevant goals would be employee goals, and the role of the employer would be to help employees reach those goals.

3. Prenatal Care and Infant Mortality

Using the latest medical techniques, physicians are able to keep alive low-weight babies whose lungs would have collapsed and caused death only a few years ago. These techniques are used to rescue crack babies and other premature infants.[8] Then the real expenses begin. These babies usually have severe medical problems that require lengthy treatment that can ultimately cost more than $1 million per baby. The tragic irony is that the hospitals delivering the medical care are often in inner-city neighborhoods where as many as one-third of expectant mothers do not receive basic prenatal care and a few hundred dollars of medical services might have prevented the problem in the first place.

With each passing year, doctors get better at the lifesaving techniques, breaking all previous records in their ability to rescue babies at lower weights and after fewer months of pregnancy. There seems to be no limit to the money they can spend. But who decides that it's appropriate to spend so much on low-weight babies and so little on prenatal care for their mothers? Certainly not the people in the neighborhoods that the medical facilities are designed to serve. Most of those being helped know little about the latest advances in medical science and not much more about prenatal care. The decisions are made by politicians and the health care bureaucracy.

The problem is especially acute in the black community. Nationally, a black woman with a family income of less than $10,000 a year is almost twice as likely as a white woman with similar income to give birth to a low-weight baby and about four times as likely to do so as a white woman with an annual family income of more than $40,000.[9] Overall, black babies die before their first birthday at twice the rate of white babies, which may partly explain why life

[8]Low-weight babies are usually premature babies.

[9]James W. Collins, Jr., and Richard J. Davis, "The Differential Effect of Traditional Risk Factors on Infant Birthweight among Blacks and Whites in Chicago," *American Journal of Public Health* 80, no. 6 (June 1990): 679–81.

Table 4.2
INFANT HEALTH IN NEW YORK CITY

Category	Low-Income Area (East Harlem)	High-Income Area (Kips Bay–Yorkville)
Infant deaths per 1,000 live births, 1989	23.4	7.3
Live births per 100 with late or no prenatal care, 1986–88	35.8	6.1
Low birth-weight babies (less than 5.5 pounds) per 100 live births, 1989	18.5	6.0
Low birth-weight babies (less than 3.3 pounds) per 100 live births, 1989	3.8	0.9

SOURCE: New York City, Department of Health; reported in *New York Times*, December 29, 1990.

expectancy at birth has been falling for blacks, although rising for whites.[10]

Table 4.2 compares infant health statistics between the low-income, minority area of East Harlem and the high-income area from Kips Bay to Yorkville in New York City. As the table shows, expectant mothers in East Harlem are six times less likely to receive prenatal care and three to four times more likely to have a low-weight baby.

Before turning to possible solutions, it is important to correct four common misconceptions. First, the high rate of infant mortality in

[10]According to the National Center for Health Statistics, life expectancy for blacks at birth fell continuously from 69.7 years in 1984 to 69.2 years in 1988, the last year for which statistics are available. Over the same period, life expectancy for whites at birth increased from 75.3 years to 75.6 years. In addition to infant deaths, other reasons for the decline in black life expectancy include deaths from homicide, motor vehicle accidents, and AIDS.

inner-city areas is unquestionably affected by lifestyle decisions (drinking, smoking, taking drugs, etc.) and it is not clear that any amount of spending on prenatal care will appreciably change the lifestyles of expectant mothers.[11] Second, even when all income and educational differences between blacks and whites are removed, a substantial difference in birth outcomes remains. For example, middle-class, college-educated black women are twice as likely to give birth to low-weight babies as white women with the same levels of income and education.[12] Third, not all minorities face the same problem. The infant mortality rate for Hispanic mothers is about the same as for white mothers, and in New Mexico it is lower. The difference between Hispanics and blacks may be partly attributable to values and culture.[13] Finally (as discussed in chapter 17), although the United States has one of the highest rates of infant mortality among developed countries, once mothers and their babies enter the health care system, American doctors outperform those in any other country. Mothers are also in better hands. A woman in Japan is twice as likely to die during childbirth as a woman in the United States.[14]

Proposals in the Cost-Plus Health Care System. Most proposals from those who hold a bureaucratic view would expand the current bureaucracy and increase the number of dollars under its control, either by increasing the number of expectant mothers covered by Medicaid or by making prenatal care free to all women under a limited program of national health insurance. What these proposals overlook is that prenatal care is already free for low-income women in most inner-city areas, through Medicaid or other government programs. Yet (as made clear in chapter 3), free prenatal care is not necessarily easy to obtain.

Solutions in the Ideal Health Care System. If low-income women could draw on a special Medicaid account (and purchase care the

[11]One study found that nearly 30 percent of babies born in New York hospitals were addicted to crack. See Harmeet K. D. Singh, "Stork Reality: Why America's Infants Are Dying," *Policy Review* (Spring 1990), pp. 56–63.

[12]Collins and Davis.

[13]Robert Pear, "The Hard Thing about Cutting Infant Mortality Is Educating Mothers," *New York Times*, August 12, 1990.

[14]Joseph Schnelman, "Japan's Healthy Babies—An American Doctor's View," *World Health Forum* 10, no. 4 (1989): 69.

way other pregnant women do), or if they had their own medical savings accounts, they could become real consumers exercising real buying power in the market for prenatal care. That would not solve the problem of lifestyle choices, but it would create new opportunities for people to meet their health care needs.

4. Preventive Medicine

Many medical procedures can potentially save lives and, possibly, money. They include chest x-rays, mammograms, pap smears, and cholesterol tests. Between 1980 and 1986, according to a study in the *International Journal of Epidemiology*, there were 121,560 deaths from disorders that are not usually lethal if discovered and treated early. They included deaths from appendicitis, pneumonia, gallbladder infection, hypertensive heart disease, asthma, and cervical cancer.[15] About 80 percent of the premature deaths reported in the study were among blacks, even though blacks make up only 13 percent of the U.S. population.

If we knew in advance which patients had serious problems, solutions would be relatively easy. But often we don't know. As a result, there is considerable debate over how many people should be tested and how frequently. One thing we do know, however, is that some people who should realize they have a problem fail either to see a physician or to receive the necessary preventive care.

The problem is especially acute in low-income areas, where there are sometimes epidemics of diseases many people thought had been eradicated only a few years ago. Some inner cities now report skyrocketing rates of tuberculosis, hepatitis A, syphilis, gonorrhea, measles, mumps, whooping cough, etc. All too often, those who are infected see physicians too late. For example, at Harlem Hospital in New York City, only 30 percent of the women diagnosed with breast cancer live as long as five years, compared with 70 percent of white women and 60 percent of black women in the country as a whole.[16]

[15]Eugene Schwartz, Vincent Y. Kofie, et al., "Black/White Comparisons of Deaths Preventable by Medical Intervention: United States and the District of Columbia 1980–1986," *International Journal of Epidemiology* 19, no. 3 (September 1990): 592.

[16]Elizabeth Rosenthal, "Health Problems of Inner City Poor Reach Crisis Point," *New York Times*, December 24, 1990.

Such statistics have led many to conclude that America's private health care system is not serving low-income people and that a public system is needed. This view overlooks the fact that many of the people who are apparently not receiving needed preventive care are already part of a free public system, partly supported by funds collected from low-income, minority taxpayers. New York City, for example, is experiencing an epidemic of congenital syphilis (with about half the cases in the country), a surprising increase in cases of measles, and increasing instances of other preventable diseases.[17] Yet, the city has perhaps the most extensive system of free health care and free public hospitals in the country.

In addition to low-income families (that presumably face financial constraints), many nonpoor families that can afford to purchase preventive care choose not to do so. One reason may be that diagnostic tests themselves expose patients to risks. According to one study, from 5,000 to 10,000 cases of breast cancer each year may be caused by x-rays.[18] Health insurance companies, which clearly have a direct financial interest in such questions, generally do not require or encourage preventive medical tests. But the perspective of insurers may not be the best guide. Since people frequently switch carriers, insurers have less financial interest in the long-run consequences of a failure to detect a medical problem. And paying for diagnostic tests through insurers often doubles the cost of the tests.

Moreover, carefully conducted economic studies do not confirm that preventive medicine pays for itself. With the exception of targeted high-risk groups, preventive medicine generally adds to the cost of health. It is an investment in future good health, not a cost-control device.[19] Further, attitudes toward risk vary. Risk-averse people place a higher value on preventive medicine than do those who are less risk-averse. Yet, in the current health care system, the delivery of preventive medical services tends to be determined by bureaucratic reimbursement policies rather than patients' preferences.

[17]Ibid.

[18]Michael Swift, Daphne Morrell, et al., "Incidence of Cancer in 161 Families Affected by Ataxia-Telangiectasia," *New England Journal of Medicine* 325, no. 26 (December 26, 1991): 1831–36.

[19]See Louise B. Russell, *Is Prevention Better than Cure?* (Washington: Brookings Institution, 1986).

Proposals in the Cost-Plus Health Care System. Commonly proposed solutions are to force private insurers to cover diagnostic tests (with no out-of-pocket cost to the patient), change Medicare rules to achieve the same objective for elderly patients, and make diagnostic tests free to targeted groups through a limited national health insurance program. Each of these proposals would use health insurance as a vehicle for the prepayment of the consumption of medical services. They would probably double the cost of the services. And they would give all decisionmaking power to third-party payers. As we shall see in chapter 17, countries that make all health care free to patients at the point of consumption do not necessarily expand the scope of preventive medicine. In the United States, we already perform more diagnostic tests than are performed in most countries with national health insurance.

Solutions in the Ideal Health Care System. An ideal health care system would recognize that the answer to the question of whether a test is worth its cost depends as much on patient preferences and attitudes toward risk as on cost-benefit calculations. In the ideal system, patients would be the principal buyers of health care, and test manufacturers would market directly to them, as well as to health care providers. Health insurance would not be used as wasteful prepayment for the consumption of medical care. Instead, public policy would encourage private savings for diagnostic tests.

5. Child Care

In recent years, rates of preventable childhood diseases have soared, especially in low-income areas of large cities. For example, the number of whooping cough cases has tripled since 1981, there were 17,000 measles cases in 1989, up from only 1,500 in 1983, and measles is at epidemic levels in many major cities.[20]

Former Colorado governor Richard Lamm complains that this is evidence that our national priorities are wrong. At the same time we are expanding Medicare to cover heart transplants for the elderly, 20 percent of America's children do not get all of their vaccinations.[21] But is a 100 percent vaccination rate ideal? Consider that every vaccine has risks of its own, including a small risk of death. In the

[20]U.S. Public Health Service data.

[21]Richard D. Lamm, "Again, Age Beats Youth," *New York Times*, December 2, 1990, p. A16.

case of the pertussis vaccine, used to prevent whooping cough, the risk of disease of the brain (encephalopathy) is 1 in 110,000, and the risk of permanent brain damage (and possibly death) is 1 in 310,000. Although the risks are low, they are considerably higher than the risk levels allowed by most federal health and safety regulatory agencies. On the other hand, if a child gets whooping cough, the risk of brain damage is 1 in 240, and for babies less than six months old the risk of death is 1 in 100.[22] Given such odds, we would expect parental attitudes to vary considerably. We would also expect fewer vaccinations at those times and in those areas where the risk of whooping cough is lower. As whooping cough neared eradication in 1981, vaccination rates dropped, and that was certainly a rational response. Since then, the incidence of the disease has risen, making vaccination more desirable.

The problem of preventive treatment for children is not solely, or even mainly, a problem of private-sector medicine. Some people estimate that about half of unvaccinated children who get measles are covered by Medicaid or some other government program, even though the cost of a complete set of vaccinations is only about $91.[23] Britain, where free health care is available to everyone through the National Health Service, has had worse problems than the United States. When parent fears over the whooping cough vaccine in that country led to sharply lower immunization rates, a six-year epidemic followed, with 104,000 whooping cough cases leading to almost 400 deaths.[24]

In addition to the issue of children's vaccinations, there is the more general issue of how often children should see physicians and what preventive medical procedures should be performed on apparently healthy children. The American Academy of Pediatrics (with an obvious financial interest in the issue) recommends 12 well-child care visits to physicians for children from birth through age six. Studies by the Rand Corporation and the U.S. Office of

[22]Data are from the U.S. Centers for Disease Control and the American Academy of Pediatrics. Reported in Sonia L. Nazario, "A Parental Rights Battle Is Heating Up over Fears of Whooping Cough Vaccine," *Wall Street Journal*, June 20, 1990.

[23]Robert Pear, "Proposal Links Welfare Funds to Inoculations," *New York Times*, November 29, 1990.

[24]See Aaron Wildovsky, *Searching for Safety* (New Brunswick, NJ: Transaction Publishers, 1988).

Technology Assessment fail to support that recommendation. In fact, aside from inoculations, it's not clear that a case can be made for any well-child care visits to a physician.[25] From an economic point of view, the exercise appears to be wasteful.

Arguably, there are social reasons (the control of communicable diseases) to care about inoculations. But the argument does not extend to physician visits for apparently healthy children. The justification for well-child care appears to be relief of anxiety or reassurance for parents. But those are private benefits, not social ones. Despite this fact, politicians around the country are making well-child care an issue under the slogan "You can't say 'no' to children." Florida was the first state to mandate that private insurers cover a specific number of physician visits for children at different ages, with no deductible or copayment for the insured family.[26] Even though such laws double the cost of routine care, encourage spending in excess of any expected social benefit, and raise the cost of real insurance, they are being actively considered in virtually every state.

Proposals in the Cost-Plus Health Care System. Those who take a bureaucratic view of health care tend to endorse a technocratic view as well. Whether a preventive medical procedure should be performed on a particular patient is a matter for the experts to decide, they maintain. Patient preferences and attitudes are irrelevant.

The technocratic view lies behind state laws that require vaccinations for school-age children and the Bush administration's proposal to make childhood vaccinations a precondition for receipt of welfare or Medicaid benefits.[27] This view is almost always endorsed by medical associations. For example, although 19 states allow parents to forgo the whooping cough vaccine for "philosophical or religious" reasons, the American Medical Association would like to rescind that right.[28] The American Academy of Pediatrics actively

[25]See Judith Wagner, Roger Herdman, and David Alpers, "Well-Child Care: How Much Is Enough?" *Health Affairs* (Fall 1989).

[26]John C. Goodman and Gerald L. Musgrave, *Freedom of Choice in Health Insurance*, NCPA Policy Report no. 134 (Dallas: National Center for Policy Analysis, November 1988).

[27]Pear, "Proposal Links Welfare Funds to Inoculations."

[28]Nazario, "A Parental Battle Is Heating Up over Fears of Whooping Cough Vaccine."

lobbies state governments to require private insurers to cover well-child care, with no copayment or deductible.

The experts, of course, are often wrong. For example, the swine flu vaccine, heavily promoted by the federal government, led to numerous unnecessary deaths among elderly patients.[29] But a more basic objection to the technocratic view is that the experts are rarely disinterested. Take cholesterol tests for children. Researchers whose medical journal articles encourage such tests often have a personal research interest in seeing the tests promoted. Companies that make cholesterol-testing devices have a financial interest in their use, as do the physicians who charge for the test.[30] Thus, under prodding from the experts we have seen a rise in cholesterol testing in children in recent years, even though the best evidence indicates that routine testing is a waste of money.[31]

Solutions in the Ideal Health Care System. The alternative to the technocratic view is the recognition that experts often disagree and acceptance of the fact that the preferences and levels of risk aversion of parents are important. The agenda presented in chapter 3 seeks to ensure that families have resources set aside to pay for child care, including child vaccinations. But parents, not the medical bureaucracy, should decide what care to obtain and how much to spend obtaining it.

6. Lifestyle and Health

Medical researchers are increasingly convinced that health is determined in important ways by lifestyle—what we eat, what we drink, whether we smoke, whether we exercise regularly. Table 4.3, for example, shows that researchers believe that the major causes of cancer are lifestyle-related and have very little to do with

[29]Robert Formaini, *The Myth of Scientific Public Policy* (New Brunswick, NJ: Transaction Books, 1990).

[30]Gina Kolata, "Routine Child Cholesterol Tests: Doubts," *New York Times*, December 19, 1990.

[31]Ronald M. Lauer and William R. Clarke, "Use of Cholesterol Measurements in Childhood for the Prediction of Adult Hypercholesterolemia," *Journal of the American Medical Association* 264, no. 3 (December 19, 1990): 3034–38; and Warren Browner et al., "The Case against Childhood Cholesterol Screening," *Journal of the American Medical Association* 264, no. 3 (December 19, 1990): 3039–43.

Table 4.3
CAUSES OF CANCER DEATHS

Cause of Cancer	Percent of All Cancer Deaths[1]
Diet	35%
Tobacco	30
Infection	10
Reproductive and sexual behavior	7
Occupation	4
Alcohol	3
Geophysical factors (for example, sunlight)	3
Pollution	2
Medicines and medical procedures	1
Industrial products	1[2]
Food additives	1[3]

SOURCE: Richard Doll and Richard Peto, "The Causes of Cancer," *Journal of the National Cancer Institute* 66 (June 1981): 1256 (Table 20).
[1]These numbers represent the midrange of estimates from various studies. The numbers do not add up to 100 because the estimates from different studies are not consistent.
[2]Less than 1 percent.
[3]Less than 1 percent and possibly negative because some food additives prevent other causes of cancer.

pollution, pesticides, and other risks over which individuals have little control.[32]

It is important to emphasize that much of what we think we know about the relationship between lifestyle and health is conjecture, not scientific fact. For example, researchers have observed that the Japanese have lower rates of certain types of cancer than Americans. Yet when the Japanese immigrate to the United States (and presumably adopt American eating habits), after one or more generations their cancer rates are very similar to those of other Americans. This evidence is highly suggestive, but not conclusive.

It is also important to note that lifestyle changes may not increase life expectancy. Some evidence indicates that a normal human life

[32]See also the discussion in Richard Stroup and John C. Goodman, *Making the World Less Safe: The Unhealthy Trend in Health, Safety and Environmental Regulation*, NCPA Policy Report no. 137 (Dallas: National Center for Policy Analysis, April 1989).

span is about 85 years, regardless of what we do. Lifestyle may have a lot to do with how much we spend on health care during those 85 years, however.[33]

Proposals in the Cost-Plus Health Care System. In a collectivist, bureaucratic environment, the lifestyle choices of any one person impose costs on others. Thus, the economic incentives to make good choices are greatly reduced, and individual choices become social problems. Almost all solutions to such problems within the context of the cost-plus system involve putting group pressure on individuals to change their behavior.[34] Thus, corporations institute programs to encourage lifestyle changes.[35] Governments institute programs that either persuade or coerce, such as laws requiring the use of motorcycle helmets and auto seat belts, and excise taxes for alcohol and tobacco products.

Solutions in the Ideal Health Care System. Recognizing that "a man convinced against his will, is unconvinced still," the ideal health care system would internalize as much as possible the costs and benefits of lifestyle choices. If it is true that health is the consequence of a lifetime of decisionmaking, then decisionmakers should have financial incentives to plan for health care spending over a lifetime. Both Medisave accounts and MIRAs would enable individuals to profit from the financial and the physical/medical aspects of good lifestyle choices. In the health insurance marketplace, we would also expect people with riskier lifestyles to be charged higher premiums. Evel Knievel should not pay the same health insurance premiums as you and I. In the ideal health care system, we may have altruistic reasons to encourage others to adopt good lifestyles. But, for the most part, we are not forced to pay for their bad choices. Group pressure and cultural influences may help, but self-interest and financial incentives are the keys to changing behavior.

[33]See James F. Fries, "Aging, National Death, and the Compression of Morbidity," *New England Journal of Medicine* 303 (July 17, 1980): 130–35; and James F. Fries, Lawrence W. Green, and Sol Levine, "Health Promotion and the Compression of Morbidity, " *The Lancet* (March 4, 1989): 481–83.

[34]See the articles on "promoting health" in *Health Affairs* (Summer 1990).

[35]Many corporations have adopted physical fitness programs out of a desire to reduce health care costs, even though the evidence of success is fragmentary and weak. Others are refusing to hire people with risky lifestyles or are charging them higher health insurance premiums. See the discussion below.

7. *People Who Are Uninsurable because They Have Preexisting Health Care Problems*

A small, but not inconsequential, number of people are unable to purchase private health insurance because they have a known—usually expensive-to-treat—health problem. As Table 4.4 shows, health insurers either refuse to cover such people or exclude them from coverage for the preexisting illness. Of course, the primary reason that people with a serious preexisting condition want health insurance is to get an insurer to pay for medical expenses they are virtually certain to incur.

A related problem occurs when people become sick while covered by one insurance carrier, but then are forced to leave that carrier and search for another, either because they change jobs or because the original insurer cancels the policy. The original insurer covers the first phase of the illness, but any new insurer tries to avoid paying for its subsequent treatment. These problems also affect other people. Large companies with health insurance plans that pay for any and all conditions, preexisting or otherwise, attract employees with medical problems, thus contributing to the companies' health insurance costs. In addition, uninsured people with such problems may generate unpaid hospital bills, which then must be paid by everyone else.

It is not surprising that private insurers refuse the obligation to pay for clearly foreseeable medical expenses. If they charged a fair premium, it would be roughly equal to the future medical expenses plus the cost of administering the policy. People with preexisting medical problems would have nothing to gain by purchasing such insurance. Still, many people face severe financial problems because they have high medical bills and no health insurance.

Before turning to solutions, it is worth asking why we do not have a similar problem in a related field: life insurance. The answer is that most people have the opportunity to buy life insurance that is "guaranteed renewable" long before they develop a serious illness. As a result, they can continue paying premiums and can expect a large payment to their beneficiaries even if they are diagnosed with a terminal illness.

Interestingly, most individual and family health insurance policies sold in the 1950s were also guaranteed renewable. If a person became sick while covered by a health insurance policy, that person

Table 4.4
SOME HEALTH CONDITIONS THAT FREQUENTLY CAUSE HIGHER PREMIUMS, AN EXCLUSION WAIVER, OR DENIAL OF INSURANCE

Higher Premium	Exclusion Waiver	Denial
Allergies	Cataract	AIDS
Asthma	Gallstones	Ulcerative colitis
Back strain	Fibroid tumor (uterus)	Cirrhosis of liver
Hypertension (controlled)	Hernia (hiatal/inguinal)	Diabetes mellitus
Arthritis	Migraine headaches	Leukemia
Gout	Pelvic inflammatory disease	Schizophrenia
Glaucoma	Chronic otitis media (recent)	Hypertension (uncontrolled)
Obesity	Spine/back disorders	Emphysema (severe)
Psychoneurosis (mild)	Hemorrhoids	Stroke
Kidney stones	Knee impairment	Obesity (severe)
Emphysema (mild-moderate)	Asthma	Angina (severe)
Alcoholism/drug use	Allergies	Coronary artery disease
Heart murmur	Varicose veins	Epilepsy
Peptic ulcer	Sinusitis (chronic or severe)	Lupus
Colitis	Fractures	Alcoholism/drug abuse

SOURCE: U.S. Office of Technology Assessment, 1988.

could count on coverage for medical bills indefinitely into the future. Today, it's almost impossible to find a health insurance policy that is guaranteed renewable. Why? There are apparently three reasons. First, because state regulations impose onerous burdens on any insurance company that sells such policies, they have been regulated almost out of existence. Second, the tax law has encouraged the development of a health insurance system that is almost entirely employer-based, despite the increasing mobility in U.S. labor markets; when people switch jobs, they almost always have to switch health insurance policies, and the new carrier typically tries to avoid paying for preexisting illnesses. Third, government policy has encouraged health insurance to evolve into prepayment for the consumption of medical care. To a large extent, real health insurance no longer exists.[36]

Proposals in the Cost-Plus Health Care System. The most common proposals would force insurers to cover preexisting illnesses, often with no additional premium. Many state-mandated health insurance benefit laws already attempt to do that with respect to certain health conditions. Under proposals being considered in many states, insurers would not be able to deny anyone a health insurance policy, or charge a higher premium, because of a preexisting condition. The losses that insurers incur would be subsidized by a tax imposed on all health insurance sold in the state. Another proposal would create state risk pools that would allow patients with preexisting conditions to purchase health insurance at subsidized rates. In most states that already have risk pools, the losses are covered by taxing the health insurance premiums of everyone outside the pool.[37]

Each of these proposals would use health insurance to prepay for the consumption of medical care. People who are already sick would pay premiums well below the actuarially fair value. The losses would be subsidized by forcing others to pay more than the actuarially fair value. In other words, these proposals would force some people to pay for the medical expenses of others. Although the objective may seem humane, the proposals are highly regressive, imposing special burdens on low-income families in order to

[36]The problems with health insurance and the reasons for the changing nature of health insurance are discussed in greater detail in the next section of this book.

[37]The exception is Illinois, which subsidizes the losses from general tax revenues.

benefit middle- and upper-income families. As is the case with existing state-mandated benefits laws (which also primarily benefit the middle class), the proposals would raise the price of insurance, thereby imposing a tax on low-income consumers or causing more of them to forgo health insurance altogether.

Solutions in the Ideal Health Care System. If there is a social reason to bail out uninsured people with high medical bills, the efficient way would be through direct monetary payments to those people. An income-related system of disability payments would accomplish that goal. If there is a social reason to subsidize health insurance for some, the efficient and fair way to do it would be to make the subsidy income related, giving the most help to those with the greatest need. Our recent experiences with risk pools suggest that the size of the subsidy would not have to be that large. Currently, about 13 states have mature risk pools, which have been in operation for some period of time. In general, people with preexisting conditions are able to buy into the pool for premiums that average about 50 percent higher than comparable policies for other people (see chapter 11). Even with the high premiums, these risk pools lose about $53 million a year. By one estimate, if this system were extended to all the states, the nationwide deficit would be about $300 million,[38] less than one-twentieth of 1 percent of the nation's annual health care bill. Under a system of public subsidies, with the subsidy falling as income rises, the taxpayer's burden would be even smaller.

In the ideal health care system real insurance, with actuarially fair premiums, would be encouraged and promoted. Government programs to help those in need would work within the context of a competitive health insurance market, rather than undermine the market. Moreover, many of the problems discussed here would never arise in an individualized health insurance marketplace. If health insurance were tailored to individual needs, not employer needs, it would anticipate job changes, the long-term consequences of recurring illness, and other problems. If health insurance were sold in a competitive marketplace, it would probably resemble life

[38]Karl J. Knable, Morris Melloy, and C. Keith Powell, "State Health Insurance Risk Pools," *Health Section News*, no. 21, April 1991, pp. 9–12.

insurance. Because guaranteed renewable policies are valuable and desirable, a market for such policies would quite likely develop.

8. The Rising Number of People Who Lack Health Insurance

In addition to the uninsurable, there is a much larger number of people who could buy insurance but choose not to. The estimated 34.4 million Americans not covered by either private or public insurance represent about 16 percent of the population. Interestingly, 85 percent of the uninsured are members of a family with a working adult, and more than half of them live in families with an adult who has steady, full-time employment.[39]

There is considerable debate over the dimensions of this problem and how much difference it makes. For example, although as much as 16 percent of the population is uninsured at any point in time, only 4 percent is uninsured for two years or more.[40] Thus, being uninsured is similar to being unemployed. Although many people may experience being uninsured over the course of their work lives, only a small number experience it for a long time. Still, it is a problem that is exacerbated by unwise government policies.[41]

We have already identified three reasons for this problem. First, state legislatures keep passing regulations that increase the price of

[39]Jill D. Foley, *Uninsured in the United States: The Nonelderly Population without Health Insurance* (Washington: Employee Benefit Research Institute, April 1991). These estimates are based on the March 1990 *Current Population Survey* and differ somewhat from other estimates. For example, the actual number of uninsured may be closer to 30 million people—about 12.4 percent of the population—and the proportion of uninsured with a workforce affiliation may be only 65 percent, rather than 85 percent. See the summary of the literature in Michael A. Morrisey, "Health Care Reform: A Review of Five Generic Proposals," paper presented at "Winners and Losers in Reforming the U.S. Health Care System," a policy forum sponsored by the Employee Benefit Research Institute Education and Research Fund, Washington, October 4, 1990.

[40]See C. Nelson and K. Short, *Health Insurance Coverage: 1986 to 1988*, U.S. Bureau of the Census Report, no. 17 (1989), p. 70. Reported in Louis P. Garrison, Jr., "Medicaid, the Uninsured, and National Health Spending: Federal Policy Implications," *Health Care Financing Review*, 1990 Annual Supplement, p. 169.

[41]Just as it is easy to minimize the problem, it is also easy to exaggerate it. The figure of 63 million uninsured Americans, widely reported by the national news media, includes people who lacked health insurance for brief periods (rather than continuously) during a 28-month sample period examined by the U.S. Bureau of the Census. See Spencer Rich, "28% in U.S. Seen Lacking Steady Health Insurance," *Washington Post*, April 12, 1990.

Table 4.5
PEOPLE WITHOUT HEALTH INSURANCE, BY FAMILY INCOME LEVEL, 1989

Family Income	Number of People (Millions)
Under $5,000	4.7
$5,000–$9,999	5.0
$10,000–$14,999	5.6
$15,000–$19,999	4.6
$20,000–$29,999	5.9
$30,000–$39,999	3.2
$40,000–$49,999	1.9
$50,000 or more	3.3
Total	34.4

SOURCE: Jill D. Foley, *Uninsured in the United States: The Nonelderly Population without Health Insurance* (Washington: Employee Benefit Research Institute, April 1991), Table 5 (p. 25).
NOTE: Does not add to total due to rounding.

health insurance. As many as one out of four uninsured people may have chosen not to purchase health insurance because of the price-increasing effects of state regulations. Second, people not covered by employer-provided health insurance are discriminated against under tax law. Unlike employees of large companies, they must pay health insurance premiums with aftertax dollars, effectively doubling the cost for many of them. Third, tax law and employee benefits law are causing employers to act in ways that result in even more employees and their dependents going without health insurance. As Table 4.5 shows, these policies have the greatest impact on low-income families.

Even if they were not priced out of the market by bad public policies, many uninsured people conclude there is no reason to buy health insurance. If they get sick, they find ways of becoming insured through an employer's plan. Even if they cannot get insurance, they still get medical care—paid for by someone else.

Proposals in the Cost-Plus Health Care System. Some commonly discussed proposals are to force everyone to purchase health insurance, force employers to purchase insurance on behalf of all their

employees,[42] expand the number of people covered by Medicaid and state risk pools, and force everyone to participate in a system of national health insurance. Each of these proposals, though, ignores the principal reason why people lack health insurance in the first place: They are denied the opportunity to buy it at actuarially fair prices with equal advantage under federal tax law. Instead of encouraging market competition and giving individuals more control over their health care dollars, the proposals would force people to buy into a defective system of third-party insurance coverage and undermine the development of a genuine health insurance market.

Solutions in the Ideal Health Care System. Under an ideal health care system, people would face fair prices for insurance, sold in a freely competitive market. Special-interest politics would not artificially inflate health insurance premiums. All people would receive the same tax advantage for the purchase of insurance, regardless of employment. And people would have stronger incentives to purchase health insurance before they develop chronic illnesses. The ideal system would not ignore the fact that health insurance premiums may be beyond the means of some families. But the solution is to empower the families, not impersonal third-party bureaucracies. Through a system of tax credits, low-income families would be encouraged to exercise free choice as buyers in a health insurance marketplace.

9. Uncompensated Hospital Care

Each year, American hospitals have about $8 billion in uncollected charges. It is not clear how much of this amount is unpaid because people cannot afford to pay and how much is unpaid simply because the hospitals make insufficient efforts to collect. Some studies suggest that half of uncollected hospital bills are generated by patients who have health insurance coverage.[43]

[42]Because employers will not employ people unless the value of the employee's output is roughly equal to the value of his or her compensation, forcing employers to provide health insurance is equivalent to forcing them to substitute a fringe benefit (health insurance) for wages. This issue is considered at greater length in chapter 12.

[43]See Robert M. Saywell et al., "Hospital and Patient Characteristics of Uncompensated Hospital Care: Policy Implications," *Journal of Health Politics, Policy and Law* 14, no. 2 (Summer 1989): 287; and Congressional Research Service, *Costs and Effects of Extending Health Insurance Coverage* (Washington: October 1988), pp. 101, 103.

Almost all businesses have some bad debts. But consumers seldom have reason to care. In the health care system, things are different. Third-party payers pay not only for the medical care of their policyholders, but also for the bad debts of others. In other words, the hospital rates that you and I pay are partly determined by how many other patients fail to pay. Bad debts are not distributed evenly among the nation's hospitals. For example, a special problem arises for hospitals designated to receive charity patients. In many communities, this is the county hospital. County hospitals complain that they are undercompensated from public funds for the care they provide. They also complain of patient dumping—the practice of transferring charity patients from other hospitals to county hospitals, in some cases risking the health of the patient.[44]

Proposals in the Cost-Plus Health Care System. The most common proposals are similar to those for dealing with the uninsured. They would force all people to have health insurance, either through their place of employment or through national health insurance. Those proposals could cost in excess of $100 billion, while reducing hospital bad debts by only about $8 billion.

Solutions in the Ideal Health Care System. In an ideal health care system, hospitals would be expected to cover their costs while charging competitive prices to all patients. Some provision would exist to reimburse hospitals for indigent care under carefully defined conditions. When those conditions are met, the best solution would be to reimburse hospitals from public funds rather than attempting to shift the cost of care to other patients. If hospitals are required by law to treat patients, whether or not the patient can pay, then the government (and voter/taxpayers) imposing this requirement should be willing to pay the cost. This provision should not relieve hospitals of the responsibility of collecting fees, however. Those with excessive bad debts would be allowed to fail. One reasonable method for funding indigent care (as we discussed in chapter 3) would be based on a fair system of tax subsidies for the purchase of health insurance. Those who choose not to insure would pay higher taxes, and the extra tax payments could serve as

[44]See L. M. Beitsch, "Economic Patient Dumping: Whose Life Is It Anyway?" *Journal of Legal Medicine* 10, no. 3 (1989): 433–87; and "'Dumping' Mandated by Law," *AAPS News* 47, no. 1 (January 1991).

a pool of funds from which to pay for free care delivered at charity hospitals.

In an ideal health care system, people would be encouraged to insure for major illnesses and save for minor ones. But no one would be forced to do so. People who failed to purchase health insurance would pay higher taxes, and people who incurred bad hospital debts would suffer financial penalties, the same as for other bad debts.

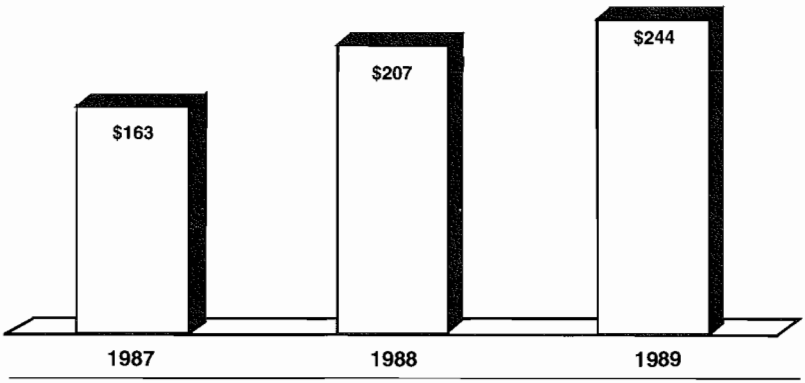
10. Health Insurance Coverage for Substance Abuse and Mental Health

In a competitive health insurance market, it is very difficult to insure for treatment of alcohol or drug abuse or mental health problems. The majority of people—those who do not have or expect to have such problems—would choose not to purchase optional coverage for them. Those choosing it almost certainly would have a problem and intend to file claims. A fair premium for such coverage, then, would be extremely high—roughly equal to the cost of medical claims that are almost certain to be incurred. Such a premium would simply be prepayment for the consumption of medical care. As a result, coverage for alcoholism, drug abuse, mental health, and similar illnesses is almost never offered as an option in individual policies unless state law requires it. Coverage for these items is almost always found in group policies (where individuals are not given choices) and in states that mandate it. Where coverage is available, its cost tends to be quite high, especially since there are few objective standards for determining when an "illness" is present, when it has been "cured," and what treatment is "necessary." Small wonder that almost unlimited amounts of money can be spent.

When patients paid for alcohol and drug abuse treatment out-of-pocket, the treatment of choice was usually Alcoholics Anonymous (AA). The program is incredibly cheap, and it's still not clear that any other program is better.[45] Once third-party insurers started paying the bills, however, programs sprang up everywhere and costs began to soar.

[45]Most studies find little difference in the methods of treatment, including no difference in inpatient versus outpatient care. See, however, D. C. Walsh et al., "A Randomized Trial of Treatment Options for Alcohol-Abusing Workers," *New England Journal of Medicine* 325, no. 11 (September 12, 1991): 775–82.

Figure 4.5
MENTAL HEALTH COSTS PER EMPLOYEE AT LARGE CORPORATIONS, 1987 TO 1989



SOURCE: A. Foster Higgins & Co., *Health Care Benefits Survey, 1989: Mental Health and Substance Abuse Benefits.*

Among those paying are large corporations with generous health insurance programs. As Figure 4.5 shows, company spending for mental health benefits has increased by 50 percent in only two years.[46] Often the benefit goes to an employee dependent, rather than the employee, covering problems ranging from eating disorders and sexual abuse to "codependency." One critic contends that mental health hospitals are becoming "dumping grounds for adolescents whose parents want nothing to do with them." One-fifth of all private psychiatric hospital admissions are now patients under age 18.[47]

Proposals in the Cost-Plus Health Care System. Most people with a proposal urge us to ignore the costs and force all policyholders to have coverage for alcohol and drug abuse, mental health, and related treatments.[48] Their proposals would extend prepayment of

[46]See, however, Richard Frank, David Salkever, and Steven Sharfstein, "A New Look at Rising Mental Health Insurance Costs," *Health Affairs* (Summer 1991), pp. 116–23.

[47]Tim W. Ferguson, "Any Wonder Medical Premiums Are Anything But Shrinking," *Wall Street Journal*, May 22, 1990.

[48]See, for example, the articles on "Paying for Mental Health Care" in *Health Affairs* (Spring 1990).

medical care through third-party insurers to an area in which cost containment is extremely difficult, and the costs would be reflected in everyone's health insurance premiums.

Solutions in the Ideal Health Care System. In an ideal health care system, people would always be free to purchase policies tailored to individual and family needs; insurance would never be used as a vehicle for the prepayment of medical care; and if insurers were to reimburse policyholders for unexpected alcoholism, drug dependence, or mental illness, the policyholders and their families would become the principal buyers of medical care at the time it was administered, perhaps using insurance reimbursement funds. When people are paying out-of-pocket for alcohol and drug abuse therapy, they won't pay much unless the treatment is clearly more valuable than the free therapy offered by Alcoholics Anonymous. Furthermore, in the ideal health care system, people are encouraged to save for precisely those contingencies for which it is impossible to insure in a competitive marketplace.

11. Medical Expenses for the Terminally Ill

In America, we spend an enormous amount of money on patients who are very near death and occasionally on patients who (for all practical purposes) are already dead. In the Medicare program alone, we spend almost one out of every three dollars on elderly patients who are in the last year of their lives; as much as one out of every ten Medicare dollars is spent on elderly patients within the last 40 days of their lives.[49] In some highly publicized cases, families have been forced to sue hospitals to disconnect artificial life support systems from loved ones who had become little more than human vegetables. These facts are surprising only if we view health care dollars as primarily belonging to patients and if we view patients and their families as the primary customers of hospitals. They are not surprising once we acknowledge that most health care dollars are transferred from bureaucracy to bureaucracy, far out of reach of patients and their families.

Unlike in the United States, cancer patients in Britain are spared not only the high cost of death but also the agony of painful therapies. Terminally ill cancer patients in Britain are often sent to hospices, where they are given heroin injections to ease their pain. The

[49]Estimates of the U.S. Department of Health and Human Services.

British solution seems sensible, but with one caveat. In Britain, as in America, the money is controlled by bureaucracies, not by patients and families. So it's not clear whether the choice of a hospice over continued treatment reflects family preferences or bureaucratic rationing. Cancer patients with the potential to be cured are much better off in the American health care system.[50]

It is interesting, once again, to contrast health insurance with life insurance. Prudential Insurance Company has announced plans to pay life insurance benefits to terminally ill patients prior to their death. Other insurers are considering following suit, on the theory that people should be able to enjoy their death benefit in the last months of life.[51] Because the primary health insurer of terminally ill patients is the federal government (Medicare), we are not likely to see innovation on the health insurance side. But there is the opportunity to merge the British approach to terminal illness with the approach of U.S. life insurance companies. Patients could be given a choice to take some portion of the money that would be spent on high-technology care and use it to live out their remaining months in a more pleasant hospice environment—or, for that matter, to take a Caribbean cruise.

Proposals in the Cost-Plus Health Care System. Aside from the almost universally accepted concept of a living will, the most common proposals involve the creation of more bureaucracies—that is, committees of experts (even more removed from families than are hospital physicians) who will search for ethical answers to these difficult questions.

Solutions in the Ideal Health Care System. In an ideal health care system, patients and families would control the health care

[50]Cancer treatment rates in Britain are much lower than in the United States, with 10,000 to 15,000 British cancer patients failing to receive chemotherapy relative to U.S. levels. See Henry J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing Hospital Care* (Washington: Brookings Institution, 1984). The British system is discussed more fully in chapter 17.

[51]Payments can be in the form of a lump sum or a monthly annuity. The principal obstacle is government. State regulators have to approve the scheme and, as of January 1990, only ten had done so. Some state insurance laws prohibit accelerated death benefits, and there is some fear that the Internal Revenue Service will try to tax them, although life insurance benefits are normally not taxable. Tamar Lewin, "Terminally Ill Can Collect Death Payout While Alive," *New York Times*, January 27, 1990.

dollars and—most of the time—hospitals would respond to family wishes. The role of the hospital would be to inform the patient and family of their choices.

12. Long-Term Nursing Home Care for the Elderly

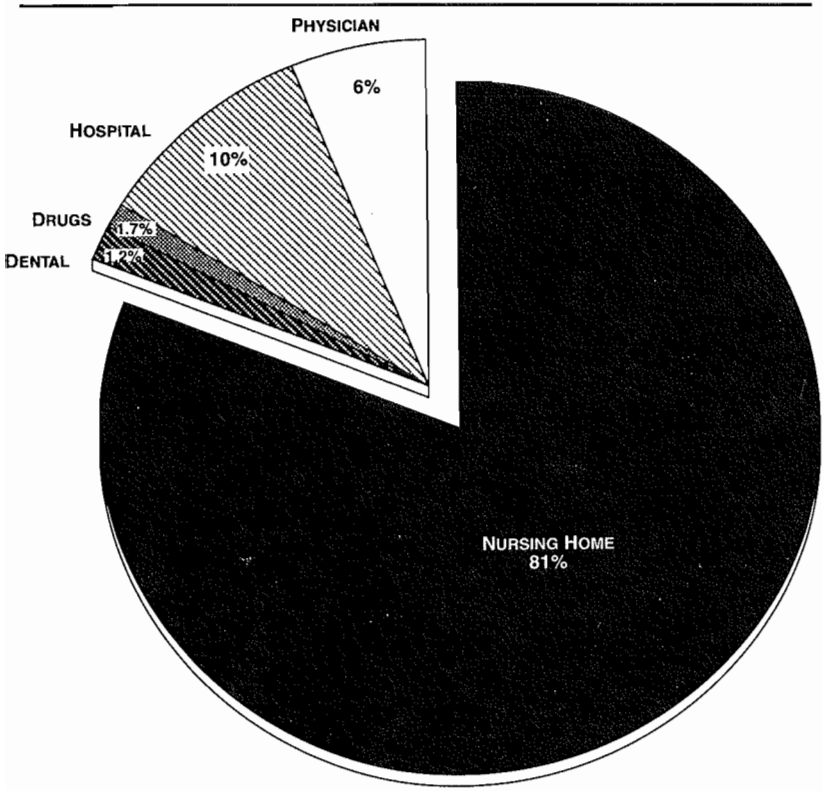
Currently, Medicare does not pay for long-term nursing home care for elderly patients. Medicaid (for the poor) will pay, but only after an elderly patient has exhausted virtually all personal financial resources. One consequence is that nursing home care is the largest single health care expense likely to confront an elderly individual. As Figure 4.6 shows, among out-of-pocket expenses for the elderly in excess of $2,000, about 81 percent goes for long-term care.

Is there a need for additional nursing home care for the elderly? That's not clear. For every elderly person in a nursing home, two other—equally disabled—elderly people are not. This situation reflects the fact that, when people are forced to pay with their own money, many find cheaper options. Nursing home care costs about $25,000 a year, in part owing to government regulations that require most nursing homes to be structurally safer than the average Hilton hotel. For the most part, Medicaid patients in nursing homes cannot take the money spent on their behalf and try to find the same care for a lower price. As with other parts of the health care sector, the system is not designed to help patients find a good deal or a reasonable price. Rather, it is designed to funnel billions of dollars into nursing homes.

There is very little private insurance for nursing home care. One reason is that it is extremely difficult to construct objective definitions of the circumstance under which nursing home care is indicated. Entry into a nursing home requires a physician's statement that the treatment is necessary, but physicians often base their judgments, not on the patient's medical condition, but on family preferences. Nursing home care very often is a choice about living arrangements rather than a medical necessity. Another reason for the lack of long-term care insurance is federal tax policy, which creates tax subsidies for health insurance for current medical expenses but disallows tax deductions for premiums for future medical expenses. Savings or insurance premiums for future medical expenses must be paid with aftertax dollars.

There is no question that if nursing home care were provided free to the elderly, the demand would soar. Some estimate the

Figure 4.6
ANNUAL OUT-OF-POCKET EXPENSES FOR THE ELDERLY IN EXCESS OF $2,000



SOURCE: Health Care Financing Administration.

additional cost at $60 billion a year, but it could be much higher. If every elderly person spent one year in a nursing home, the total cost would be about $627 billion per year.

Proposals in the Cost-Plus Health Care System. Most current proposals encourage us to ignore the costs and extend free nursing home care to elderly Medicare patients. In general, such proposals would concentrate even more power over long-term care dollars in the hands of a federal bureaucracy. They would not give the elderly more choices.

Table 4.6
COST OF ORGAN TRANSPLANTS IN THE UNITED STATES

Type of Transplant	Cost	One-Year Survival Rate
Kidney (living)	$30,000	96%
Kidney (cadaver)	30,000	91
Pancreas	40,000	91
Liver	230,000	60–70
Heart	110,000	80
Heart-Lung	200,000	65
Bone marrow	95,000	13–55
Cornea	5,250	55–90
Lung	240,000	35

SOURCE: *Health Span*, June 1991; reprinted in *Medical Benefits* 8, no. 15 (August 15, 1991), Table 1 (p. 6).

Solutions in the Ideal Health Care System. Under an ideal health care system, patients would not stay in nursing homes if they could find better options at lower prices. Real long-term care insurance would make payments to people, not nursing home administrators. Individual patients would enter nursing homes only if the services offered were worth the price. Moreover, an ideal tax system would encourage savings for long-term care.

13. *Organ Transplants, Designer Drug Therapy, and Other Lifesaving but Expensive Medical Technologies*

One of the strangest features of health care politics is the inordinate effort to get coverage for items that most people can afford to pay for out-of-pocket (for example, mammograms and pap smears) and the lack of attention to coverage for inordinately expensive, lifesaving technologies that few could pay for out-of-pocket. To the degree that there has been any real discussion of organ transplants, for example, the focus has not been on the need to insure for such procedures but on how to decide, bureaucratically, who among the uninsured will get transplants.

Most people are not insured for organ transplants. Yet, as Table 4.6 shows, if the need arose most people would find it difficult to pay for one. Although we frequently hear that the constraint on

Table 4.7
ORGAN TRANSPLANTS IN THE UNITED STATES: NEED VERSUS SUPPLY

Type of Transplant	Number of Transplants Performed	Number of Additional People on the Waiting List
Kidney	9,560	17,938
Pancreas	549	473
Liver	2,656	1,242
Heart	2,085	1,794
Heart-Lung	50	226

SOURCE: United Network for Organ Sharing, *Transplant Statistics* (Richmond, VA, 1991).

transplants is a lack of donors (see Table 4.7), an additional constraint is money. Kidney transplants are less expensive and usually paid for by government. Other transplants often must be paid for with private funds.[52]

In addition to organ transplants, other emerging technologies have great promise but will be very costly. One of the most intriguing is "designer drugs." These drugs are tailor-made for a specific patient, based on the patient's DNA makeup. In the future, undoubtedly there will be other technologies that promise to save lives but carry price tags far beyond the financial means of most people.

Proposals in the Cost-Plus Health Care System. Proposals usually fall into two camps: those to get government to fund expensive procedures that hospitals are already performing and want to perform more of, and those to set up rationing committees to determine which uninsured patients receive the treatment. The focus of the proposals is on institutions and the money they will have to spend, not on patients and their preferences. For example, it is almost never suggested that a patient should be able to choose between having an expensive procedure done or keeping the money to spend for some other purpose.

[52]See Robert H. Blank, *Rationing Medicine* (New York: Columbia University Press, 1988).

Solutions in the Ideal Health Care System. In an ideal health care system, insurers would have incentives to develop policies anticipating new technologies and helping people insure for them. New, lifesaving, expensive technologies are viewed as the enemy of today's health insurers, who often refuse to pay on the grounds that treatments are experimental, sometimes even after they have been proved effective. Once health insurers get out of the business of buying health care, however, they will see new technologies as a reason why policyholders should buy more insurance, so they can afford the technologies if needed.

14. Health Care Rationing

Because we could in principle spend many times our gross national product on health care, it must be rationed in some way. The primary way in which it is rationed in the United States is by individual choice. When the expected cost of medical care exceeds its expected benefit, people forgo it. For example, some people choose self-medication with nonprescription drugs. What deters them from going to the doctor's office every time is the physician's fee, the time cost, the travel cost, lost wages, and other inconveniences. As discussed earlier, if everyone who purchased nonprescription drugs saw a physician instead, the United States would need 25 times the current number of physicians.

For years, advocates of socialized medicine have argued that all health care (*all* health care) should be free at the point of consumption and that it is unfair (and perhaps also unwise) to ask people to compare the value of health care with the cost of getting it. But if health care were made absolutely costless, the system that provides it would collapse into chaos. Thus, even in countries such as Britain and Canada where health care is theoretically free, people are deterred by other costs (including waiting costs) and an enormous amount of self-rationing goes on.

The alternative to self-rationing is bureaucratic rationing. For example, many large companies are seeking ways to deter health care spending. Most are opting for bureaucratic solutions. But at least one company, Hewlett Packard, has announced a plan that explicitly calls for employee rationing by choice. The plan involves many of the concepts discussed in this book, including giving patients more information, encouraging choices between money

and medical care, and using physicians as "patient advisers rather than technicians or deliverers of care."[53] Until recently, rationing by bureaucracy in the private sector was rare, confined largely to organ transplants and occasional triage situations in hospitals. Rationing is more frequent in the public sector and is increasing in the Medicare and Medicaid programs.

Outside the United States, every country that has national health insurance rations health care through bureaucracies. It is almost never done through open, rational debate. Instead, politicians limit the budgets of hospitals or of area health authorities and leave rationing decisions to the health care bureaucracy. Indeed, politicians almost never admit that they are in any way responsible for rationing.

Among the characteristics of health care rationing as practiced in other developed countries (as discussed in chapter 17) are the following. If health care is rationed by bureaucracies, the tendency is to discriminate in favor of higher income patients, in favor of whites (especially male whites), and in favor of the young. The sophisticated, the wealthy, and the powerful almost always find their way to the head of rationing lines. Whereas markets empower individuals, bureaucracies empower special interests.

Rationing decisions in the United States appear to be no different. Studies have discovered that, when transplants are rationed, bureaucracies appear to discriminate on the basis of income, race, and sex. For example, a study by the Urban Institute found that, for black and white males, the higher their income, the more likely they are to receive an organ transplant.[54] In 1988, according to the United Network for Organ Sharing, whites received 97.6 percent of the pancreases and high percentages of livers, kidneys, and hearts; and men received 79.2 percent of hearts, 60.6 percent of

[53]Karl Palzer, "Rationing by Choice," *Business and Health* (October 1990), pp. 60–64.

[54]Phillip J. Held et al., "Access to Kidney Transplantation: Has the United States Eliminated Income and Racial Differences?" *Archives of Internal Medicine* 14 (December 1988): 2594-2600. A likely reason for the discrepancy is Medicare reimbursement policies, which place greater burdens on lower income patients. Prior to 1987, Medicare did not pay for outpatient drugs such as cyclosporine, which can cost transplant patients up to $5,000 per year. It would be irrational to spend $50,000 on a transplant and have it rejected because the patient could not afford $5,000 in medication. Currently, Medicare pays for 80 percent of immunosuppressive drugs for one year.

kidneys, and 54.4 percent of pancreases.[55] According to the American Society of Transplant Physicians, although the rate of end-stage renal disease is four times higher among blacks than among whites, blacks constitute 28 percent of the kidney patients and receive only 21 percent of the kidney transplants.[56] The *Pittsburgh Press* found that if the donors were not living relatives, the average wait for a kidney transplant in 1988 and 1989 was 14 months for black patients and only 8.8 months for whites.[57]

In the United States, the elderly have a privileged position with respect to health care. Medicare covers virtually all of them, plus a small percent of people under 65 (the disabled). But in other countries, where the entire population is part of the same government-funded health care plan, the elderly are usually pushed to the end of the rationing lines. Thus, in Britain, it is extremely difficult for an elderly patient to get kidney dialysis or a kidney transplant—or any other transplant, for that matter.[58] Moreover, pressures that have developed in other countries are developing in our own. Former Colorado governor Richard Lamm and other prominent individuals (including "medical ethicists") are calling for rationing health care to the elderly and reallocating the funds to the younger population.[59]

Proposals in the Cost-Plus Health Care System. Until a few years ago, the practitioners and defenders of cost-plus medicine did not believe in health care rationing. Their goal was to lower all financial barriers through public and private insurance and to meet any and all needs. Today, almost everyone recognizes that rationing is necessary. Many people in the modern cost-plus bureaucracy not

[55]Associated Press, May 20, 1989.

[56]Bertram L. Kasiske, John F. Neylan III, et al., "The Effect of Race on Access and Outcome in Transplantation," *New England Journal of Medicine* 324, no. 5 (January 31, 1991): 302–7

[57]Reported in the *Dallas Morning News*, August 19, 1990.

[58]See John C. Goodman and Gerald L. Musgrave, *Health Care for the Elderly: The Nightmare in Our Future*, NCPA Policy Report no. 130 (Dallas: National Center for Policy Analysis, October 1987); and Aaron and Schwartz, *The Painful Prescription*.

[59]For a summary of these views, see Norman G. Levinsky, "Age as a Criterion for Rationing Health Care," *New England Journal of Medicine* 322, no. 25 (June 21, 1990): 1813–15.

only accept rationing but also welcome it with open arms—provided, of course, that it is controlled by the (health care) bureaucracy and not by individual patients.[60]

Solutions in the Ideal Health Care System. In an ideal system, rationing would be by patient choice wherever possible. The system would be organized so that people would have the funds necessary to purchase health care through medical savings and reimbursements from insurers. But people would have strong incentives not to purchase health care unless the expected value of the care were greater than the monetary costs. Patients, of course, could consult their physicians. But the power of choice would be in the hands of the patients, not the bureaucrats.

15. Unnecessary Medical Care

Robert Brook of the Rand Corporation maintains that "perhaps one-fourth of hospital days, one-fourth of procedures and two-fifths of medications could be done without."[61] James Todd, executive vice president of the American Medical Association, disagrees.[62] But evidence produced by Rand researchers has become part of the national health care debate.[63]

Rand researchers first discovered wide variations in 123 medical procedures for Medicare patients in various parts of the country. The rate at which the procedures were performed varied by as much as 6, 7, or 8 to 1, with no apparent explanation. Areas that were high in performing one procedure were often low in performing another. The Rand study was consistent with other studies of non-Medicare patients, which have found widespread variations in medical practice across geographical areas for several decades. Just knowing about the variations, however, did not reveal whether some patients were being shortchanged and others overtreated.

[60]For a representative point of view, as well as a good review of the literature on rationing, see Blank.

[61]Robert H. Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?" *Journal of the American Medical Association* 262, no. 21 (December 1, 1989): 3028.

[62]Ron Winslow and Sonia L. Nazario, "AMA, Rand Go after Modern Ill: Unneeded Procedures," *Wall Street Journal*, March 22, 1990.

[63]A summary of Rand Corporation research may be found in Mark R. Chassin, ed., *The Appropriateness of Selected Medical and Surgical Procedures* (Ann Arbor, MI: Health Administration Press, 1989).

Table 4.8
RAND CORPORATION STUDY ON UNNECESSARY MEDICINE AS REPORTED BY THE NATIONAL MEDIA

	Panel's Assessment[1]		
	Appropriate	Equivocal	Inappropriate
Coronary angiography[2]	74%	9%	17%
Carotid endarterectomy[3]	35	32	32
Upper gastrointestinal endoscopy[4]	72	11	17
Overall	60	18	22

SOURCE: Rand Corporation study results, reported in the *Wall Street Journal*, March 22, 1990.
[1]Based on medical records of 5,000 Medicare patients.
[2]Use of x-rays and dye to explore obstructions of the heart.
[3]Surgical removal of obstructions in major arteries to the brain.
[4]Fiber-optic examination of the esophagus, stomach, and upper intestine.

Consequently, a follow-up Rand study collected medical records for 5,000 Medicare patients and convened a panel of experts to judge the appropriateness of three procedures. The results (as reported by the national news media) are shown in Table 4.8. As the table shows, in more than a fifth of the cases, the procedure performed was judged to be inappropriate and therefore unnecessary. For carotid endarterectomy (the removal of plaque in major arteries to the brain), the procedure was judged to be appropriate only about one-third of the time.[64]

Before we jump on the doctors, it's worth noting that in some ways the Rand study was unfair. Suppose we convened experts in your field and asked them to review decisions you have made. Would they agree with every decision? You might respond, as the doctors do, that you didn't have the opportunity to consult with a panel of experts before you made your decisions. A second problem with the Rand results is the way in which they have been reported. What Rand means by "equivocal" is that a majority of the experts

[64]"Appropriateness" is not determined by Monday morning quarterbacking. It is based on indications prior to the procedure. A procedure is judged appropriate if the expected benefit (increased life expectancy, relief of pain, etc.) exceeds the expected negative consequences (mortality, morbidity, etc.) by a margin sufficient to justify the procedure. See Chassin.

Table 4.9
ANOTHER VIEW OF THE RAND STUDY ON UNNECESSARY MEDICINE

	Percent of Time 7 of 9 Experts Agree That Procedure Is		
	Appropriate	Inappropriate	Total
Coronary angiography	50%	12%	62%
Carotid endarterectomy	13	17	30
Upper gastrointestinal endoscopy	46	7	53
Overall	36	12	48

SOURCE: Rand Corporation, as reported in Robert H. Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?" *Journal of the American Medical Association* 262, no. 21 (December 1, 1989): 3021.

couldn't agree. But in newspaper reports, the word "equivocal" often became "questionable" (as in "40 percent of the procedures were either inappropriate or questionable"), which is not the same thing. Equivocal means that not performing the procedure is just as problematic as performing it. A third problem is that media reports of the Rand study obscured the actual extent of disagreement and uncertainty in the medical community. The reason why Rand had to convene a panel of experts was that researchers could not answer questions about appropriateness by merely consulting the medical literature. Once the experts were convened, they were far less unified than is commonly known.

Table 4.9 presents a different way of looking at the Rand study, showing the number of times that 7 of 9 experts agreed (the two opinions ignored are the two most extreme views, on either side of the middle). As the table shows, when 7 of 9 experts were asked to agree, they found only 12 percent of the procedures to be inappropriate, not 22 percent. And even this degree of consensus is misleading. In the Rand study, each expert initially expressed a personal judgment. Then they met in group discussions (where group pressure had an opportunity to forge a consensus), after which several members often changed their minds.[65] Indeed, the most

[65]"Disagreement among the panelists diminished following their discussions, but by no means disappeared." Chassin, p. 8.

remarkable fact about the Rand study was that even with all of those efforts to arrive at a definitive judgment, 7 of 9 experts could agree that the procedures were either definitely appropriate or definitely inappropriate less than half the time.

So when Rand spokesmen state that 40 percent of surgery is "unnecessary," that's a personal point of view, not the unanimous conclusion of experts. Rand researchers have adopted the viewpoint that, if physicians can't agree that surgery should be performed, it should not be. Rand research, however, shows something different. The fact that the experts couldn't agree in half the cases tells us much more about the state of medical science than about the state of medical practice.

A fourth problem is that the data from the Rand study were for 1981, more than a decade ago. Generalizing about today's health care based on what happened in 1981 is clearly wrong. The 1980s produced major changes in the way hospitals are run. For better or for worse, American physicians today are scrutinized more closely by peers and third-party payers than physicians anywhere else in the world. There are probably still cases in which experts would agree that the surgery promised more harm than good, but those cases are likely to be presented to disciplinary committees and are probably far less than the 12 percent shown in Table 4.9.

A fifth problem is that Rand researchers tried to develop a purely medical test to determine whether surgery should have been performed, when the real problem they were trying to address was an economic one.[66] Their study compared the medical benefits of procedures with the medical harm. However, as noted above, cases in which the expected medical harm exceeds the expected medical benefit are probably quite rare. The real question is whether procedures are worth their cost. And the only people who can accurately answer that question are patients who can choose to spend that same money on other goods and services.

A final problem is that the Rand research is frequently used by advocates of socialized medicine to criticize the U.S. system of private

[66]With reference to the numbers in Table 4.9, Rand's Robert Brook agrees that, from a purely medical perspective, perhaps only 12 percent of the procedures (which all the experts agree should not be done) are unnecessary. But when economic factors are considered, perhaps only 36 percent of the procedures (which all the experts agree should be done) are justified. Brook, 3027.

medical care. What the critics fail to mention is that countries with national health insurance also experience wide variations in medical practice. In Britain, for example, physicians have no direct financial interest in performing any medical procedure. But the rate at which British general practitioners refer patients to hospital physicians varies by at least 4 to 1 and, according to one study, by 25 to 1. Moreover, there is a high correlation between patient referrals and subsequent hospital admissions.[67]

What can we conclude? The most important implication from the Rand study is that medical practice is still more an art than a science, and that when physicians are faced with difficult choices, they may not be able to get firm direction either from the medical literature or from a national panel of experts. A second implication is that a small number of physicians may be systematically putting their patients at risk by using clearly inappropriate procedures—and, if that is the case, something should be done about it. A third implication is that patients who are told they need a medical procedure should ask questions before agreeing to it, especially if the procedure is expensive or risky.

Can medicine be made more scientific? Some apparently think so. The American Medical Association and the Rand Corporation are working to develop "practice guidelines" for physicians considering certain procedures, and Congress has mandated that the Department of Health and Human Services draw up similar guidelines. The goal is the development of "computerized protocols" that will let physicians know what they should do when confronted with certain patient symptoms and conditions.

Will the guidelines work? That's not clear. Many people believe they will be a waste of money. Some argue that their development is such a lengthy process that medical science will have outpaced them by the time they are available. In other words, computerized protocols will always be years behind scientific developments in medicine. Others raise the philosophical objection that computerized protocols assume correct medical procedures usually can be determined by a computer program, which obviously has never met or talked to the patient. Studies have not borne out that assumption,

[67]Office of Health Economics, *Variations between General Practitioners*, OHE Briefing no. 26 (July 1990).

however. In one test, judgments of general practitioners were matched with three different computerized protocols in the treatment of patients with abdominal pain; the GPs outperformed the protocols in every test.[68]

If workable computerized protocols were available to physicians, they might prove to be valuable tools. A physician could consult the computer, then substitute his own judgment where appropriate. Less complicated protocols might become available to patients for use on their home computers, giving advice on whether to see a physician, for example.

On the other hand, if computerized protocols and practice guidelines were used to control the behavior of physicians and patients, they could threaten the quality of medical care. And, unfortunately, that threat is real. Researcher Robert Brook has argued that the Rand Corporation's techniques can be used to ration health care under the Medicare system, if Medicare funds run short.[69]

Proposals in the Cost-Plus Health Care System. Lurking behind the public discussion of practice guidelines is a fundamental difference of philosophy that is rarely discussed in print. The bureaucratic view of health care is usually also a technocratic view. Its more extreme proponents are fundamentally antiphysician and antipatient, in the sense that they believe the attitudes and judgments of individuals are largely irrelevant. Ultimately, the technocrats do not see the computer as an aid to physicians and patients but as a substitute. They envision medical practice being literally dictated for the country as a whole from a central location in—well, Washington.

Although the discussion of practice guidelines frequently is couched in terms of helping physicians make good decisions, the technocrats also see the guidelines as a means of exerting control. In their view, physicians who substitute their own judgment for the computer's should have to prove that they are right, which would require them to use cumbersome and costly bureaucratic procedures. As a result, instances in which the guidelines were not followed would be rare and unusual events.

[68]Jane Orient, "An Evaluation of Abdominal Pain: Clinicians' Performance Compared with Three Protocols," *Southern Medical Journal* 79, no. 7 (July 1986): 793–9.

[69]Brook, 3029.

Solutions in the Ideal Health Care System. In an ideal system, patients would become far more involved in the decisionmaking process. They would have new opportunities to learn about the potential costs and benefits of medical procedures and to make decisions based on their evaluations of those costs and benefits. The role of the physician would be to help patients make those difficult decisions, based on their own values. To the extent that computer programs can be a real aid to patients and physicians, they would be used for that purpose. But people would not surrender their decisionmaking authority. Most important, patients would not be told there is only one correct way of treating a condition when the opinions of physicians vary. When professional opinions diverge, patients would be the first to know. Most unnecessary surgery today is unnecessary only in the sense that it's not worth the cost. In an ideal health care system, patients would be encouraged to weigh its benefits against its costs and have the option of forgoing the procedure and spending the money elsewhere.

16. Medical Ethics

It is widely believed that the Hippocratic oath embodies a code that has formed the basis for physicians' decisions from the time of ancient Greece to the present day. Recent scholarship has brought this notion into question, however. There is strong evidence that the Hippocratic oath was not written by Hippocrates. Further, the code may have represented the ethical and medical views of a small religious sect—views explicitly rejected by mainstream Greek physicians. Moreover, the Hippocratic oath contains positions both on ethics and on medical science that the vast majority of modern physicians reject.[70]

Although many physicians still honor the tradition and general sentiments of the Hippocratic oath, as a practical matter, the oath is largely ignored in modern medicine. Yet one of its legacies is the injunction that a physician, if unable to heal or cure, shall do no harm. To some physicians, the injunction implies that they should

[70]Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation* (Baltimore: Johns Hopkins Press, 1943). See also W.H.S. Jones, *The Doctor's Oath: An Essay in the History of Medicine* (Cambridge, MA: Cambridge University Press, 1926); and Wesley D. Smith, *The Hippocratic Tradition* (Ithaca, NY: Cornell University Press, 1979).

do everything possible to ensure the physical well-being of their patients. Or, given that almost everything in medicine is probabilistic, it implies to some that they should do everything that *might* help the patient. Many patients and policymakers have the same expectations. In economic terms, that means that medical science is required by medical ethics to devote resources to the healing and care of patients until such point that the marginal effect on health of the last dollar spent approaches zero. Were we to follow this injunction rigorously, we easily could spend our entire gross national product on health care many times over.

What will replace the old medical ethics? American physicians are increasingly pressured to adopt the newer ethics of cost-benefit analysis. They are supposed to compare the health value of a procedure with its monetary cost. In effect, the new ethic says: "Perform procedures until the marginal health benefit is greater than or equal to the marginal monetary cost." The new ethic results in less medical care, but it ensures that whatever we get is worth the resources it costs.

The standard objection to cost-benefit analysis is that it is impossible to compare the value of health (or of life) with the value of money. But that objection is weak. Each of us makes choices between health (and safety) and money every day, and most of us are comfortable doing so. A larger automobile is safer, but it costs more money. Walking is safer than driving, but it takes more time, and, for most of us, time is money. Indeed, we are constantly balancing health and safety against money, and we don't always come down on the side of health and safety. A stronger objection is that although we may feel comfortable making our own choices between health and money, most of us are uncomfortable making choices for others. The obvious solution is to let each individual choose. If a reasonably well-informed patient makes a choice between health care and money, then we presume the patient will choose the option that has the higher value for him or her. But for individuals to make such choices, they have to have the option of keeping the money. In today's system, each of us makes choices between our own health care and somebody else's money. Real cost-benefit analysis demands that we choose between health care and our own money.

If we deny individual choice and insist on collective decisionmaking about health care resources, then we are forced to use a different

technique. Health economists must judge (or guess) the trade-offs that an average individual would make. Such cost-benefit analysis then forces everybody else to make the same decision, even though individual preferences differ radically. The technique is justified on the grounds that we are comparing social cost with social benefit.

Because cost-benefit analysis is complicated, physicians are not trained in it, and the health care bureaucracy doesn't trust physicians anyway, no advocates of the collectivist approach suggest that physicians should implement it. Instead, they envision that technocrats will decide what procedures physicians will use under various circumstances—perhaps with the aid of the computerized protocols described above. Physicians will make far fewer ethical decisions because they will make far fewer medical decisions.

Although cost-benefit studies are routinely done by economists in and out of government in every policy field, there appear to be very few programs that are actually run on the basis of such analyses. The reason is that politics always interferes. An apparent exception was the federal government's program to administer swine flu shots to the elderly—a program that resulted in unnecessary deaths.[71]

Proposals in the Cost-Plus Health Care System. Physicians and health administrators for most of the post–World War II period were encouraged to believe that money should not even be considered in making medical decisions. Today, they are being told that money should always be considered. Moreover, because bureaucrats are usually technocrats, it is only natural that they will gravitate toward a cost-benefit standard—a collectivist standard not always in the best interest of individual patients.

Solutions in the Ideal Health Care System. At the individual level, cost-benefit analysis is simply a fancy name for routine decisionmaking. The old medical ethic led physicians to encourage patients to ignore monetary costs and focus only on health care benefits. What physicians should do is encourage patients to consider both. In an ideal system, the physician would act as adviser to patients and help them to understand the probabilities, the medical consequences of various outcomes, and the costs of various procedures. Ideally, physicians would help patients choose between

[71]Formaini.

money and health care and thus increase the odds that patients would choose the option they value most highly.

17. Administrative Costs

In 1987, according to one study, each doctor in the United States spent an average of more than 134 hours filling out insurance forms. Overall, the cost of administering the U.S. health care system was estimated to be between $96.8 billion and $120.4 billion, or almost one-fourth of total health care spending that year. By contrast, the administrative costs of the Canadian system of national health insurance were estimated to be less than one-half that high.[72] Such comparisons of the administrative costs in the United States and Canada are seriously flawed (see chapter 17). They overestimate U.S. administrative costs and underestimate Canada's. Moreover, those who assume that the United States could substantially lower its health care costs by adopting the Canadian system are engaged in wishful thinking. Countries with national health insurance try to control health care costs by limiting the amount of money that physicians and hospitals have to spend and by forcing them to ration health care. They often do so with very little oversight.

The United States, by contrast, is moving in the opposite direction. Physicians and hospital administrators spend an enormous amount of time on paperwork, not just to facilitate the exchange of money but because third-party payers also want to ensure that the medical care is appropriate and necessary. Were the United States to adopt a program of national health insurance, there is every reason to suppose that administrative costs would go up, not down. There is little chance that we would follow the Canadian practice of giving providers a fixed budget from which to ration health care with few questions asked. Nevertheless, almost everyone familiar with the administrative burdens faced by providers has concluded that the burdens are way too heavy, causing inefficiency and waste.

Proposals in the Cost-Plus Health Care System. Because the cost-plus mentality sees no value in, and no role for, a market in health

[72]Steffie Woolhandler and David U. Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine* 324, no. 18 (May 2, 1991): 1253–58. Woolhandler and Himmelstein estimated that administrative costs as a percent of total costs are between 8.4 percent and 11.1 percent in Canada and between 19.3 percent and 24.1 percent in the United States. See, however, the problems with these estimates discussed in chapters 8 and 17.

care, monopoly and central planning are almost always preferred to competition and decentralization. The concept of patients shopping in the medical marketplace and negotiating and bargaining with providers is foreign to the cost-plus way of thinking. Thus, they reason that if a single payer (read: government) wrote all of the checks, costs would be lower than they are when the checks are written by Medicare, Medicaid, and thousands of employers and private insurers.

Solutions in the Ideal Health Care System. One of the reasons why administrative costs are high is precisely because the U.S health care system is bureaucratic, rather than market-based. By contrast, one of the most important functions of competitive markets is to eliminate waste and inefficiency. More than half of the money now spent by third-party payers could instead be spent by patients out of individual Medisave accounts (see chapter 8). If those expenditures were made with health care debit cards, the administrative costs would be a little over 1 percent. Not only would there be huge savings in administrative costs, there would also be a substantial reduction in spending on unnecessary care, or care of marginal value. Overall, we estimate that if every family in America had a Medisave account covering the first $2,500 of annual medical bills, the nation's total health care spending would be reduced by as much as one-fourth, with no detrimental effect on the health of patients.

18. Health Insurance for Small Business

Health insurance has increasingly become prepayment for the consumption of medical care rather than genuine insurance, and the consequences have been especially detrimental for small business (as discussed in chapters 6 and 7).

For large companies, the evolution of the prepayment concept means that each year's premiums are determined by last year's costs. Employers pay in health insurance premiums an amount equal to the cost of whatever their employees consume. That is one of the reasons why so many large employers self-insure, sometimes using insurance companies to administer their plan. In a sense, self-insurance merely formalizes a relationship that was previously implicit between the employer and the health insurance company. Moreover, because large employers have many employees, they

have a self-contained insurance pool, and their total costs are reasonably predictable.

Insurance as prepayment for the consumption of medical care has wreaked havoc among small employers, however. The principal reason why small businesses purchase health insurance is to avoid the risk of having to pay unexpectedly large medical bills. However, because the policies they purchase are not real insurance, when a small company generates a large claim, the insurer may triple or quadruple the company's premiums and may even cancel the policy. Thus, employers who thought they were buying insurance are surprised to find out that there is very little risk sharing and, instead, they are mainly expected to pay their own way.

Before turning to solutions, it is worth contrasting small group insurance with the market for individual and family policies—about the only market where real insurance is still sold. In most states, insurers cannot raise an individual's premium without raising all other premiums (for the same type of policy) by an equal amount. Thus, insurers can't single out those who get sick and charge them more than others. Moreover, the more they raise the premiums for all policyholders, the greater the risk that healthy ones will leave the pool and buy a low-priced policy from some other insurer. Problems in the market for small groups are now stimulating reform movements in almost every state, but (as discussed in chapter 12) some reforms will only make the problem worse.

Proposals in the Cost-Plus Health Care System. One of the reasons why the cost-plus system evolved was to prevent the development of a competitive health insurance market. In the 1950s, advocates of cost-plus medical care favored "community rating," a system under which everyone paid the same premium, regardless of age, sex, occupation, or any other indicator of health care risk. Such a system was bound to fail. If everyone is charged the same premium, it will be too high for healthy (low-risk) people and too low for less healthy (high-risk) people. As fewer healthy people buy health insurance, the premium needed to cover the health care costs of those who do buy will rise in a continuous upward spiral.

Today, the intellectual heirs of the architects of the cost-plus system favor a return to community rating, either in a pure or modified form. Central to all their reform proposals is the notion that insurers should be forced to sell to anyone who wants to buy

("guaranteed issue") at prices that do not reflect real risks. Of course, the modern versions of community rating face the same problems as the older version. That is why the modern advocates also often favor employer or individual mandates, which would force people to buy health insurance whether they want to or not. The ultimate reform along these lines is national health insurance, a system under which everyone is forced to pay a tax (price) that is also unrelated to real insurance risks.

Solutions in the Ideal Health Care System. To the cost-plus mentality, the purpose of health insurance is to pay medical bills. By contrast, under an ideal health care system, the purpose of health insurance would be similar to the purpose of any other type of insurance—to allow people to protect their assets by transferring risk to others. Accordingly, an ideal system would place a high value on pricing risk accurately and encouraging a competitive market that will accomplish that task. As in the case of life insurance, however, once people have purchased a policy, insurers should not be able to change the rules of the game simply because an individual's probability of filing a claim suddenly increases.

Many of the problems in the market for small groups would disappear if small group insurance functioned in the same way as individual insurance does. One way of moving in that direction is to individualize employer-provided health insurance. Many of the problems in the market for individual insurance would disappear if health insurance more closely resembled life insurance. However (as discussed in chapters 6 and 7), achieving the ideal requires a commitment to it by policymakers.

19. The Right to Work

An efficient, productive economy requires a mobile labor market—one in which people are free to switch employers and move to new jobs where they can earn more and produce more. Yet, that goal is increasingly unattainable because health insurance is employer-based.

One problem is that workers are afraid to switch jobs because of fear that they will lose health insurance coverage or that their new employer will not cover preexisting illnesses. A *New York Times*/CBS poll found that 30 percent of Americans said that they or someone in their household have at some time stayed in a job they

wanted to leave in order to keep the health benefits, and 26 percent said that "a household member took one job rather than another mainly for health benefits."[73] A second problem is that choosing a job or staying in a job for health benefits is no guarantee of coverage since an employer can change health benefits and deny coverage even after a person has become sick. In one case, an employee with AIDS saw his maximum health benefits slashed from $1 million to $5,000 because the employer changed health insurance policies.[74]

A third problem is that employers, increasingly, will not hire people who engage in activities that increase the probability of high health costs. For example, Turner Broadcasting System, Inc. (parent of Cable News Network) is one of about 6,000 companies that refuses to hire smokers. Multi-Developers won't hire anyone who engages in high-risk activities such as skydiving, mountain climbing, motorcycling, or piloting a private aircraft. Other companies refuse to hire people who drink or who have high cholesterol levels.[75]

A fourth problem is the increase in strikes and walkouts over health insurance issues. Because employees do not see health insurance benefits as a dollar-for-dollar trade-off against wages, it is not surprising that they resist reductions in those benefits. According to the most recent survey, nearly two-thirds of the major walkouts and 30 percent of the major strikes in 1989 were over medical benefits. They included the largest, most prolonged, and most bitter labor-management confrontations, including a 17-week walkout at the Nynex Corporation and a nine-month walkout by miners at the Pittston Coal Company in Virginia, West Virginia, and Kentucky.[76]

Proposals in the Cost-Plus Health Care System. Most proposals fall into two categories: They would either impose new restrictions on employers (and employees), or they would force everyone into

[73]Erick Eckholm, "Health Benefits Found to Deter Job Switching," *New York Times*, September 26, 1991.

[74]Robert Pear, "Court Approves Cuts in Benefits in Costly Illness," *New York Times*, November 27, 1991.

[75]See Zachary Schiller, Walecia Konrad, and Stephanie Anderson, *Business Week*, August 26, 1991, reported in *Medical Benefits* 8, no. 18 (September 30, 1991): 3; and "None of an Employer's Business," *New York Times*, July 7, 1991.

[76]Alan Finder, "The New Crux of Contract Negotiations: Who Will Pay Health Care Costs?" *New York Times*, October 27, 1991.

Table 4.10
LIFESTYLE POLICIES OF EMPLOYERS

Company	Policy	Started
Baker Hughes	$10 monthly surcharge on health insurance for smokers	1990
ICH	$15 a month off medical contributions for employees who haven't smoked for 90 days and meet a weight guideline	1991
Texas Instruments	$10 monthly surcharge on health insurance for employees and dependents who smoke	1991
U-Haul International	Biweekly $5 charge for health insurance for employees who smoke or chew tobacco, or whose weight exceeds guidelines	1990

SOURCE: *Business Week*, August 26, 1991, pp. 68–72; reprinted in *Medical Benefits* 8, no. 18 (September 30, 1991): 3.

a general system of national health insurance. In the former category are proposals to mandate a basic benefit package and require the benefits to be portable, as employees move from employer to employer. Note that this proposal ignores an important source of the problem—the ability of some people to impose costs on others as a result of their behavior. Under national health insurance, the connection between individual behavior and individual costs would be severed completely.

Solutions in the Ideal Health Care System. If health insurance were individualized, policies would automatically be personal and portable. An employee would not have to fear a loss of benefits either because of a change of job or the arbitrary decision of an employer. If people engaged in more risky lifestyles, they would probably face higher premiums to reflect the greater risks. Many private insurers already charge higher premiums for certain lifestyle choices, and, as Table 4.10 shows, many employers are currently

employing this practice. But as long as individual employees pay their own way, their employability in the labor market should be unaffected. Moreover, if health insurance were individualized, there would be no reason for workers to strike over health care benefits. Employees could choose to spend as much of their compensation on health care as they individually preferred.

20. The Profit Motive in Medicine

One reason why our health care system has evolved to its current condition is a series of legislative steps designed to remove the profit motive from virtually every aspect of medicine (as discussed in chapter 5). Doctors are trained in nonprofit medical schools. Most hospitals are nonprofit, and—until recently—the health insurance industry was dominated by nonprofit entities.

One consequence of the lack of a profit motive is an industry with too few entrepreneurs and too little innovation, at least with respect to cutting costs and meeting patient needs. In those areas in which the profit motive is still the major driving force (for example, the manufacture of medical equipment and pharmaceuticals) innovation and change are rampant. But in the area of solving patient problems, cost-reducing innovations have been few and far between. Consider, for example, patients with chronic ailments. An estimated 32 million people have arthritis, 16 million have bad backs, 9 million have migraine headaches, and 23 million have allergies.[77] According to Gallup polls, one-third of Americans report they have insomnia,[78] and 70 million Americans claim they have severe headaches.[79] How innovative has the health care system been in treating these problems? Harvard University professor Regina Herzlinger has reported the statement of a patient with a bad back: "I couldn't find a multidisciplinary team that could treat my problem. So instead I went from one doctor to the next. They all offered different prescriptions. Neurologists wanted to medicate, radiologists to take pictures, orthopedic surgeons to operate, and

[77]Regina E. Herzlinger, "Healthy Competition," *Atlantic Monthly*, August 1991, p. 70.

[78]Reported in Mike Snider, "Sleepy Days Caused by Restless Nights," *USA Today*, June 20, 1991.

[79]Reported on Cable Network News.

sports-medicine types to exercise my abdominal muscles. My back still hurts!"[80]

Indications are that things are beginning to change, however. Physician entrepreneurs were largely responsible for the 1980s boom in such cost-reducing innovations as emergency care clinics and outpatient surgery units. Some physicians and pharmacists are now using 900 numbers to give telephone advice for a fee.[81] At least one for-profit company maintains a patient hotline to help people avoid purchasing more health care than they need and avoid seeing the wrong kind of physician.[82] And some physicians are now advertising package prices (including the physician fee and facility charges) for routine types of surgery.

On the other hand, physician entrepreneurs are coming under attack by those who charge that the profit motive simply contributes to escalating health care costs.[83] For example, a study conducted by the Florida Health Care Cost Containment Board found that 40 percent of Florida physicians involved in direct patient care had a financial interest in joint ventures to which they could refer patients. Patients treated at physician-owned therapy centers averaged 43 percent more visits. Although the prices per treatment or visit were lower, total costs to patients (or their third-party payers) were 31 percent higher. Clinical laboratories owned by referring physicians performed twice as many diagnostic tests per patient.[84]

It is not obvious that more tests and more physician visits are bad. However, when physicians have a direct financial interest in the therapy they prescribe, their judgment may be influenced by that fact. What should be the role of the profit motive in medical practice?

Proposals in the Cost-Plus Health Care System. One of the original goals of those who promoted the cost-plus vision of health care

[80]Herzlinger, p. 70.

[81]Leonard Stone, "For Round-the-Clock Diagnoses, Just Pick Up Your Telephone," *New York Times*, July 13, 1991.

[82]The company is Informed Access of Boulder, Colorado. See Udayan Gupta, "Enterprise," *Wall Street Journal*, January 9, 1991.

[83]Robert Pear, "When Healers Are Entrepreneurs: A Debate over Costs and Ethics," *New York Times*, June 2, 1991.

[84]*Modern Healthcare* (August 19, 1991) reported in *Medical Benefits* 8, no. 17 (September 15, 1991): 5.

was to eliminate the profit motive from the medical marketplace. That goal is still cherished by most of those in the cost-plus tradition. Hostile to the pursuit of self-interest in general, especially financial self-interest, the cost-plus mentality sees the search for profit as a source of problems, not a solution. Accordingly, the bureaucratic approach to medical care frequently favors laws barring physicians from having any financial interest in facilities to which they refer patients. Under this view, it is permissible for physicians to invest in the market for corn futures (about which they may know nothing), but impermissible for them to invest in a medical laboratory (about which they may know a great deal).

Solutions in the Ideal Health Care System. In an ideal system, self-interest would be seen as a normal and natural characteristic of human behavior. The trick is to harness this drive, so that it is directed toward solving problems rather than creating them. Historically, physicians have been the primary innovators and entrepreneurs in the medical marketplace, and that is a tradition that should be encouraged. There are plenty of ways to prevent abuse—for example, by requiring physicians to disclose their financial interest to patients. But our concern over potential abuses should not lead us to prohibit entrepreneurship in the one market where it is most needed.

Some Unresolved Problems Involving Individual Rights

Although not a subject of this book, some key issues involving the rights of individuals to make choices will become increasingly important in the remainder of this decade and in the next century. These include the right of terminally ill patients to take experimental drugs, the right of people to sell their organs to patients who need transplants, and the right to die.

A strong case can be made for allowing individuals full freedom of choice in these areas. The objection is that the choices may be irreversible and often occur under circumstances in which real patient preferences may be hard to discern and opportunities for abuse may be rife. Although that objection may justify careful procedural safeguards, the possibility of abuse cannot possibly justify a blanket, sweeping prohibition against individual choice.

Experimental Drugs for Terminally Ill Patients

The federal Food and Drug Administration (FDA) has a power that is unique in the health care system, and which in some respects

is hard to justify. Although physicians may legally engage in almost any kind of experimental surgery, they cannot administer a drug unless it has first been approved by the FDA. This is a puzzling division of power, considering that on the whole surgery is much more life threatening than drugs. Moreover, since 1976, the FDA has extended its reach, and it now controls all implanted devices, ranging from pacemakers and artificial joints to breast implants. Whereas cosmetic surgeons have virtually unlimited freedom to perform experimental breast surgery, their right to use a conventional breast implant is regulated by the FDA. In addition (as discussed in chapter 18), Medicare is citing FDA policies in refusing to pay for the latest cancer-fighting drugs.[85]

In recent years, the wisdom of investing the FDA with so much power has been called into question. AIDS patients, unable to get access to experimental drugs, have invaded the FDA's Washington headquarters in protest. Alzheimer's disease patients, unable to obtain the drug THA, have filed a class action suit. Breast cancer patients have formed an anti-FDA lobbying group, and even the National Cancer Institute has complained about FDA tardiness in approving new drugs.[86]

Such complaints are not new. In the professional literature in the 1970s, the FDA was accused of responsibility for 10,000 heart-related deaths a year because it kept beta-blockers off the U.S. market long after they had proved successful in Europe.[87] The current policy of denying people on death's doorstep an opportunity to take risks would seem unwarranted and in need of change.

The Market for Organs

Why is it legal for people to sell their "soft tissues" such as blood or semen, but illegal for them to sell their bone marrow, corneas, or solid organs for transplant? That's not clear. Under the federal

[85]These are drugs that have been approved for one use, but not for other uses—even when the practice is considered normal therapy.

[86]See, for example, "Opening Up the FDA," *Wall Street Journal*, November 15, 1991.

[87]See the discussion and the references in John C. Goodman, *The Regulation of Medical Care: Is the Price Too High?* (Washington: Cato Institute, 1980), pp. 129–32. See also Dale Gieringer, *Compassion vs. Control: FDA Investigational Drug Regulations*, Cato Institute Policy Analysis no. 72 (May 20, 1986); and Joanna E. Siegel and Marc J. Roberts, "Reforming FDA Policy," *Regulation* (Fall 1991).

National Organ Transplant Act, passed in 1984, people can give their organs to any transplant patient they wish to designate. But if they accept money in return, they are subject to a fine of $50,000, or five years in prison, or both.

The ban on the sale of organs has the effect of imposing a price of zero. And as is the case with all price controls, shortages are the natural consequence. A few other countries have taken a different course. In India, where payments for organs are legal, the going price for a kidney is $1,800, about six times the average annual wage.[88] As a result, the supply of kidneys in India is much higher than it otherwise would be. In the United States, it is evident both that there is a shortage of organ donors and that potential donors would respond to financial incentives. Accordingly, H. Tristram Engelhardt, Jr., a bioethicist and physician at Baylor College of Medicine in Houston, thinks organ sales should be legalized, but carefully regulated to prevent abuse. A growing number of his medical colleagues are coming to the same conclusion.[89]

The Right to Die

In the fall of 1991, voters in Washington state narrowly defeated a right-to-die proposition. Although most polls show that a majority of people favor the right to die, the Washington defeat occurred because of a concern about the potential for abuse. Although that concern is legitimate, the real ethical question is whether people have the right to choose how to spend their final days. Terminally ill British cancer patients often retire to hospices and spend their final days there receiving pain-relieving injections of heroin, but no heroic medical intervention. These and other options will become heated topics of debate in the United States, as increasing numbers of people assert that they, rather than health care bureaucracies, should make the final decisions.

[88]Ronald Bailey, "Should I Be Allowed to Buy Your Kidney?" *Forbes* (May 28, 1990): 367.

[89]Ibid., pp. 368–70.