



UBC CENTRE FOR
HEALTH SERVICES AND
POLICY RESEARCH

Devil Take the Hindmost?

Private Health Insurance and the Rising Costs of
American 'Exceptionalism'

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The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based at the University of British Columbia. CHSPR's mission is to advance scientific enquiry into issues of health in population groups, and ways in which health services can best be organized, funded and delivered. Our researchers carry out a diverse program of applied health services and population health research under this agenda. The Centre's work is:

- Independent
- Population based
- Policy relevant
- Interdisciplinary
- Privacy sensitive

CHSPR aims to contribute to the improvement of population health by ensuring our research is relevant to contemporary health policy concerns and by working closely with decision makers to actively translate research findings into policy options. Our researchers are active participants in many policy-making forums and provide advice and assistance to both government and non-government organizations in British Columbia (BC), Canada and abroad.

Funding and Support

CHSPR receives core funding from the BC Ministry of Health, and ongoing support from the University of British Columbia and the UBC College of Health Disciplines. This enables the Centre to focus on research that has a direct role in informing policy and health reform, and facilitates CHSPR's continuing development of the BC Linked Health Database.

Our researchers are also funded by competitive external grants from provincial, national and international funding agencies. They include the Canadian Health Services Research Foundation, the Canadian Institutes of Health Research, the Commonwealth Fund, Health Canada, the Michael Smith Foundation for Health Research, and WorkSafeBC.

Data Services: BC Linked Health Data Base

Much of CHSPR's research is made possible through the BC Linked Health Database, a valuable resource of data relating to the encounters of BC residents with various health care and other systems in the province. These data are used in a de-identified form for applied health services and population health research deemed to be in the public interest.

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The Universality of Collective Finance

In all developed societies, the financing of health care is primarily a collective process. Pools of funds, described by White (1995) as "shared savings", are assembled through more or less compulsory levies on the general population, within or outside the formal tax system. These funds are then transferred to the providers of care through institutional structures and processes that vary considerably from one country to another. But in no high-income country does direct payment by the user of services account for a major part of the total cost of health care.

Care is not, of course "free"; the residents of each country must bear, one way or another, the cost of that country's health care system. But the amount that each must contribute is largely unrelated to his/her own personal use of care. The political struggles over who pays, and who gets what, are played out through the collective funding processes specific to each country.

The results determine how much care is provided, of what types, and for whom. But they also determine who must pay -- how the costs will be distributed over the population -- as well as who will be paid, and how much, for providing care. This distribution of economic benefits and burdens, through the political process, is at least as contentious as the process of health care provision itself.

One might expect the United States, with its emphasis on "private" funding, to be an exception to this generalization. But it is not. Direct payments by users of care are projected to make up only 13.5% of total American health spending in 2005 (Heffler *et al.*, 2005). The rest flowed through various collective channels. One would have to go back to the end of the 1950s to find a time when out of pocket payment accounted for as much as half of the total; the collective share has been rising slowly but steadily for about half a century.¹

What *is* unusual about the United States, is the extent to which the assembly of these collective funds is carried out by private institutions. A substantial majority of Americans rely primarily on private insurance against health care costs. Holahan and Wang (2004) report that 65.1% of the non-elderly, non-institutionalized civilian population in 2002 had employer-paid coverage, while another 5.3% had private non-group coverage. Assuming that the elderly, military, and institutionalized all relied primarily on some form of public insurance or support, this implies that about 60% of the American population depends primarily on private coverage, while many of the elderly also have supplementary "Medigap" coverage as a retirement benefit or individually purchased. Yet the proportion of total health expenditures covered by private insurance is much less, about one third (35.7% in 2005). Private insurers, perfectly understandably, prefer not to cover people in poor health or otherwise at high risk, and place a variety of limitations on the coverage they do offer. Any shortfalls in private coverage must be paid out of pocket by beneficiaries, or shifted to the public sector.

The public sector now accounts for about 46% of health care expenditures in the United States (Heffler *et al.*, 2005). (Another 4.8% comes from other private sources.) This is still a remarkably low proportion, well below that in other developed countries. The average public share in the other high-income countries of the OECD (Organization for Economic Cooperation and Development) is about three quarters.

But the official figure is in fact a substantial understatement, because American governments also provide a large public subsidy for private health insurance, in the form of tax exemptions for coverage bought by

¹. Remarkably, however, out of pocket payments *as a share of GDP* have not changed much: 2.12% in 2005, down from 2.60% in 1960, and the ratio has fluctuated within a relatively narrow band. Meanwhile the share covered through collective mechanisms has gone up five times, from 2.7% to 13.5% of GDP.

employers for their employees.² This, in addition to several smaller subsidies, has been estimated at \$209.9 billion in 2004, or roughly 11% of total health care expenditure (Sheils and Haught, 2004).³ If they were recorded on the federal government's books as expenditures, the public share of total health care costs would be over 55%; adding in other government contributions recorded as "private" brings the total public share to about 60% (Woolhandler and Himmelstein, 2002). The contribution of private insurance (net of public subsidy) to financing American health care is only about 25%. In fact, total American *public sector* spending on health care now absorbs a larger share of national income -- about 9% -- than in any other country, and exceeds total spending in most. An extra 6% of private spending is added on top.

What is perhaps remarkable, then, is the predominant role that private insurers play both in Americans' (and others) perceptions of their health care system, and in the formulation of health care policy, despite raising a relatively small share of the money. This role sharply distinguishes the United States from all other developed countries. What are the implications of this role, in reality?

What it does not mean is that "private" insurance coverage in the United States is a commodity bought over the counter by individual consumers, along with boxes of soap flakes or cans of beans. Although it is often treated as a private consumption purchase in national statistics, and particularly in formal economic analyses, this is in fact misleading nonsense. The public subsidy to employment-based insurance, plus the problems of information flow in insurance markets -- the well-known process of "adverse selection" (Fein, 1986) -- result in a minimal market for individual private coverage.⁴ Most private health insurance in the United States is *de facto* compulsory, not "voluntary." It comes with the job -- and leaves with it.

Private health insurance is not only collectively purchased and heavily subsidized, it is also subject to considerable public regulation. In these respects it is similar to the social insurance systems in several of the European countries. There are, however, critical differences between private health insurance in the United States, and the various insurance organizations in each of the countries conforming to what White (1995) calls the "International Standard". These latter have public roles and responsibilities that are quite foreign to American experience.

First, private insurers bear no collective responsibility for the population as a whole. Over fifteen percent of Americans, about 45 million people in 2003, have no health coverage at any one time, and that number is estimated to rise to 56 million by 2013 (Gilmer and Kronick, 2005). An estimated 16 million more, non-elderly and continually "insured" adults are in fact under-insured, exposed to serious financial burdens (Schoen *et al*, 2005). In total, then, about one third of non-elderly American adults are un- or underinsured, and the proportion is likely to rise significantly over the next decade. In other developed countries the public requirement of universal, comprehensive coverage implies that all residents must have adequate coverage from some agency. Insurers collectively cannot simply wash their hands of a substantial part of

². The premiums are deductible from the employer's taxable income, but not taxed as income in the hands of the employee. This public subsidy provides the greatest benefits to people in the highest tax brackets; those with no taxable income receive no support from the general taxpayer. This "reverse Robin Hood", or "Sheriff of Nottingham" feature no doubt accounts for its political resilience.

³. It is not obvious whether private health insurance could survive in the United States without this "life support" from the public treasury.

⁴. There is a market for individual coverage, but in these contracts only about one dollar in two is actually paid out in benefits. Marketing expenses eat up much of the rest, since bad products take a lot of selling. Holahan and Wang (2004) find that private non-group insurance is the primary form of coverage for only 5.3% of their study population, which would amount to 4.5% of the total U.S. population in 2002. There is, of course, an active individual market for "medigap" insurance to cover the holes in the public Medicare program for the elderly; but this is a low-risk product precisely because it is only supplementary.

the population as "not our problem". But for-profit firms, competing in private markets can, do, and indeed must. They cannot profitably take on such public functions, and the United States is correspondingly unique in the radical incompleteness of its coverage.

Second, private insurance premiums are explicitly risk-based. People and groups at higher risk pay more. If the resulting premiums are beyond their means, they must "go bare" -- or try to find some form of public assistance specific to their circumstances. Social insurance premiums, by contrast, are largely or wholly unrelated to risk status. Moreover they typically bear some relation to wage or income level. Thus wealthier people pay a larger share of total health care costs, and sicker people pay less, than under private health insurance.

On the other hand, the premiums levied in social insurance systems are themselves less closely related to income than are the taxes in tax-financed systems. The latter thus distribute the overall burden of health care costs still more closely in accordance with ability to pay. But regardless of how, and from whom, the "shared savings" are raised, public systems do not impose higher costs on individuals with higher risk of illness.⁵ Private insurance does.

Thirdly, private insurers cannot be involved in the management of the health care system itself.⁶ In other countries, control of the payment process is a critical lever whereby governments try to influence the evolution of system capacity, costs, and coverage. Payments may come directly from governments, as in Canada, the United Kingdom, or Sweden, or flow through a large (Germany, Switzerland) or small (France, Belgium) number of health insurers that are non-profit and closely regulated. Such organizations occupy a middle ground between the strictly "private" (for-profit, commercial) and strictly "public" (line civil service) sectors. They are being subjected to increasing public regulation and accountability, largely in response to cost pressures. But a large and fluctuating group of private insurers, competing in a private marketplace, cannot be co-ordinated to manage the system as a whole.

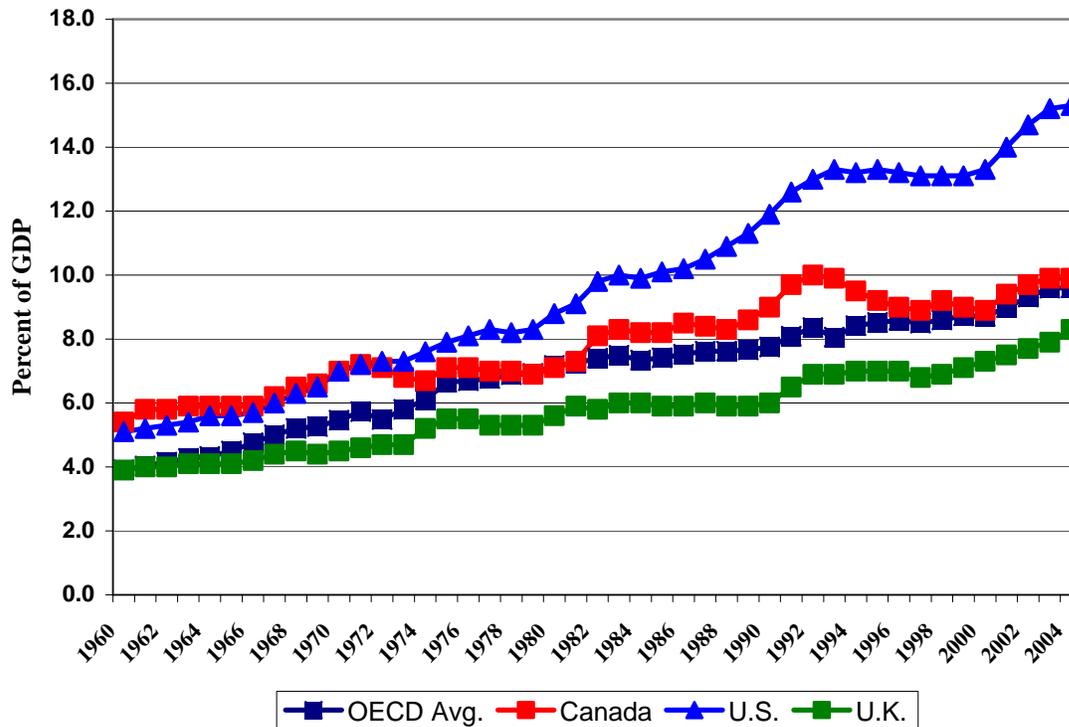
The impossibility of global system management in the United States lies behind the increasing divergence between expenditure patterns in the United States, and in the rest of the OECD. Figure I shows comparative data, from the OECD Health Data File for 2006, on health expenditures relative to Gross Domestic Product (GDP) from 1960 to 2002. The average of this ratio (unweighted, for those twenty countries with continuous data available from 1960) is bracketed by the United States on the high side, and the United Kingdom on the low. (Canada is included because of its similarity in other respects to the United States.)

⁵. All generalizations are false. *Individuals* at higher risk do not make larger contributions. But in employment-based systems, of which Germany is a leading example, people (and their employers) do contribute a larger or smaller proportion of their earnings for coverage, depending upon the overall income and health status of the membership of the Sickness Fund to which they belong. Within each Fund, however, the contribution percentage is the same for all, so higher income people pay more, and sicker people do not.

But the range of variation among Funds is limited by law, and there is enforced cross-subsidization. A portion of the contributions of members of "healthier" Funds is transferred to "sicker" Funds to reduce the burden on their membership. In particular, retired members are supported from a separate pool, drawn from the contributions of working members of all Sickness Funds. Such cross-subsidization is found in all systems of social insurance built up from separate funds.

⁶. They may become heavily involved, through setting criteria for reimbursement, in the standards of care for individual patients. But the implications, if any, for system-wide behaviour are far from clear.

Figure 1
National Health Expenditure as Percent of GDP, Selected
OECD Countries, 1960-2004



From 1960 until the mid-1970s, the OECD average ratio rises roughly in parallel with the United States, though about 1-1.5 percentage points below. These observations led several analysts in the mid-1970s to conclude that the factors driving health care costs were common to all countries, and essentially immune to public policy. The United States was more expensive only because it was somewhat farther advanced down the common trajectory.

After the mid-1970s, however, the general experience is of much slower escalation, more or less parallel to the United Kingdom. Between 1960 and 1977 the ratio of health expenditures to GDP rose at an average annual rate of 2.83% in the United States and slightly faster, 3.17% in this subset of OECD countries. But from 1977 to 2002 the average annual rate in the OECD countries fell markedly, to 1.26% while the rate in the United States has slowed only slightly, to 2.33%. Over this quarter century, these differential growth rates cumulate to 30%.

It was also during the mid- to late 1970s that governments in most European countries became concerned over the rate of escalation of health costs, and began developing mechanisms to control them (Abel-Smith, 1992; Abel-Smith and Mossialos, 1994). It became obvious that health care cost trends were indeed controllable, though with considerable political difficulty, through the choice of institutions and policies. The cost problem never goes away, but there are more and less effective approaches to management.

Concerns over cost escalation were also being expressed in the United States as early as 1970, but they could not be translated into effective policy. It has become increasingly apparent that the United States is “not a country like the others”, but is rather the “odd man out”, as Abel-Smith (1985) pointed out twenty years ago. White (1995) reached the same conclusion, referring to an “international standard” in health

care finance from which the United States alone deviates. And the deviation in costs has risen, over the last quarter-century, from 1.4 percentage points of GDP to 5.4. This is a massive difference: had American health care costs simply risen (relative to national income) in line with the rest of the countries in Figure I they would now be lower by about \$420 bn. or roughly 25%. This is the price of “American exceptionalism,” and it continues to grow.

The United States, like every other developed country, raises by far the bulk of the revenue for health care through collective institutions. Moreover, although the role of private funding is much greater in the United States than in other developed countries, private insurance (after accounting for the public tax expenditure subsidy) raises less than half as much money as the public sector. Yet this mix of financial sources has been sufficient to prevent the United States from developing public mechanisms for management and control similar to those that were worked out throughout the OECD during the 1970s, and have been progressively refined since.

The result has been a health care system that is, relative to White's "international standard", inequitable, inefficient, unpopular, and spectacularly expensive -- but enormously profitable for some Americans. The latter feature is, of course, the key to its survival.

Planes of Cleavage I: Providers versus Payers

The revenues raised to pay for health care, whether through taxes or social insurance contributions, private insurance premiums, or out of pocket payments, make up one component of a fundamental three-part accounting identity that must always hold, by definition, over all systems of health care finance. The total revenues raised to pay for health care in any society must be equal to the expenditures on health care, and each in turn must exactly equal the total incomes earned from its provision:⁷

$$\text{TOTAL REVENUE} = \text{TOTAL EXPENDITURE} = \text{TOTAL INCOME}$$

These can then be factored as:

$$T + R + C = P \times Q = W \times Z$$

where T or taxes represents revenue raised through the public sector, R represents private insurance premiums, and C is direct charges to patients. Total expenditures, in turn, are the product of the quantities of health care services provided, Q, and their average prices, P, while total incomes earned can be factored into average rates of pay, W, and the total volumes of "factor inputs" used -- person-hours, for example, or capital services -- that we label Z.

The incomes earned from health care may be salaries or net incomes from professional practice; they also include interest on hospital bonds or dividends from private pharmaceutical or equipment companies. They are earned by doctors and nurses, dentists and pharmacists, but also by employees of firms selling health insurance or providing management consulting services to hospitals or ministries of health. The channels through which funds flow may be multiple and complex, but at the end of the day every dollar that someone has paid out must have been received by someone else. And if the goods or services which

7. Strictly speaking, in an open economy the identity must be extended to account for external purchasers and suppliers of health care -- exports and imports. It would also require an explicit inter-temporal structure to allow for changes in asset levels. But these additional complications are well known from national income accounting, and add no further enlightenment to compensate for the extra notation.

that dollar of expenditure bought were defined (albeit somewhat arbitrarily) as health care, then the corresponding dollar of income was by the same definition earned by providing health care. And someone, somehow, had to contribute an equal amount of revenue to pay for it.

This elementary accounting fact underlies the primary political conflict in every health care system, that between the payers for care and the providers of care.⁸ There are also secondary conflicts on each side of this divide, among providers and among payers. But the most prominent division follows the income/expenditure distinction.

This political struggle is most evident in the universal discussions, even lamentations, over "cost explosions". In political rhetoric, health care cost trends are commonly presented as if they were some elemental force of nature, like tides or earthquakes, against which all those concerned with health policy struggle as best they can but with indifferent success. This image, assiduously promoted by providers -- and some economists -- is false (Evans, 1985, 1986) and dangerously deceptive. The real dynamic at work was expressed quite succinctly by Aaron Wildavsky (1977) as the Law of Medical Money:

"...costs will increase to the level of available funds...that level must be limited to keep costs down."

Those who pay for care are to a greater or lesser degree concerned to limit the escalation of costs. Those who are paid for care, however, are engaged in discouraging or avoiding any controls, and in trying to keep the costs rising. For the sake of political credibility they may wish to be seen to share in the general hand-wringing about the relentless pressure of health care costs. But in actual fact, many if not most providers of health care believe that the adoption of appropriate priorities would lead to more spending, not less -- at least on those services in which they have a professional interest and typically a commercial interest as well. This in turn would by definition increase the total of incomes earned from health care, making a larger total pie to share. When $P \times Q$ rises, so does $W \times Z$ -- that is what an identity means. Successful cost containment, on the other hand, means that someone in the system takes a wage or fee cut (W falls), or loses a job (Z falls). It cannot be otherwise.

i. Meeting Needs or Marketing Services - How Much Care Is Enough?

In making their case to the rest of society for more resources, and resisting pressures for cost containment, those who are paid for providing care focus primarily on the quantity of services. No matter what the current level of provision, there are always alleged to be unmet needs, and more money is needed to meet them. Furthermore these needs are constantly being increased by allegedly external forces of one sort or another -- the aging of the population, the progress of technology, public expectations, AIDS, violence...

Specific "explanations" of increased need may in principle be tested empirically. Some have been shown to be valid, others have been conclusively refuted. But general claims of increasing need survives any particular specific refutation, because they are in reality offered not as a testable account of causality, but as a form of product advertising. They are the classic "Your money or your life!" argument; if more resources are not forthcoming people will die, or at least suffer, unnecessarily. We must "meet the needs."

⁸. Not "buyers" and "sellers". The dominance of collective funding, combined with professional self-regulation and external public regulation, and rooted ultimately in the obvious fact that most users of health care are not able to define their own needs without professional help, implies that the images of the "free market", with voluntary exchange of goods/services for money, between fully informed, self-interested, autonomous and unconstrained transactors, exist only in the dreamworld of neoclassical economic theory.

Such an argument is probably as old as medicine itself. At the individual level, it is the standard method whereby the therapist exerts power over the patient -- which may well be in the patient's best interest. "Doctor's Orders" are most effective when combined with an explanation of the beneficial results of compliance -- and the ill effects of non-compliance. The relationship has a fundamental political dimension - "orders" are the exercise of power backed up by the perception of superior knowledge, and thus the ability to make credible, if not always specific, threats. "Do this, or else." Again one must emphasize that, in the individual clinical encounter, both the language and the intent may be entirely benevolent.

But since in developed societies the financing of health care is collectivized, providers must influence the controllers of those collective funds and induce them to spend more, on more different types of services. Political pressure is therefore brought to bear by convincing the relevant constituency (voters, employees, or premium-payers) of the adverse consequences of refusal. "Heartless" bureaucrats, politicians, employers, (even economists) are placing dollars above peoples' lives. Such claims, supported by human-interest anecdotes, are politically very powerful, and also sell newspapers.

Of course, as Williams (1978) has pointed out, if there is no natural limit to the scope of medicine, and if there is always some small benefit which might be gained, through sufficiently large expense, then logically it is impossible for any society to "meet all the needs" in a technical sense. Needs are infinite. It is then fundamentally a political question as to which needs -- and whose -- are "worth" meeting. Technical expertise may be necessary to determine what the payoffs to further expenditure in a particular situation might be, but the expert is no more qualified than any other citizen to state whether the benefits are worth paying for. In a democratic society everyone gets one vote.⁹

Providers accordingly seek to persuade their fellow citizens that the benefits of further expenditures are large, *i.e.* more "medical miracles". But they emphasize especially the catastrophic consequences, in health and human happiness, of any (successful) attempt to restrain the escalation of costs. In other fields of endeavor this activity would immediately be recognized as marketing.

In the United States in particular, the technique has been refined into the spectre of "rationing". Ever-advancing technology is portrayed as constantly enhancing the ability to extend and improve the quality of life and maintain function, but at ever greater cost. Sooner or later, it is argued, we shall be forced to "ration" - deny people access to effective services, let them suffer or die - for sheer lack of the necessary resources (the "Painful Prescription" popularized by Aaron and Schwartz (1984)). But in the meantime, and to postpone the evil day - send more money!¹⁰

⁹. Some might wonder why the question of "What is worth paying for?" is treated as political rather than economic. For many commodities we appeal to the principle of Consumer Sovereignty, and rely on individuals to indicate, in the marketplace, what commodities each of them believes is worth paying for. The choice process is decentralized. But the decision to leave that process to the free market -- where among other things peoples' preferences are weighted by their wealth, not by their needs -- is itself a political choice. For a variety of reasons, no country in the world has seen fit to do this for health care. In the United States, however, the very strong ideological commitment to free markets as ends in themselves is in continuous tension with powerful humanitarian values. These make citizens very uncomfortable with the results inevitably generated by markets in health care. The result has been a form of schizophrenia in health policy, and a lurching back and forth from one approach to another.

¹⁰. It may seem strange that we have grouped those who call for ever more money to "meet the needs", with those who argue that ultimately there will not *be* more money, because ever-growing demands will run into fundamental resource constraints. The critical linkage is that both assume that "more is better", and dismiss or more often simply ignore extensive evidence to the contrary. Thus in the near term, the "rationing" rhetoric serves to promote the further expansion of health care.

Health care is valued by its users, not for itself but for its anticipated (positive) impact on health. Absent this payoff, most health care services are "bads", not "goods". No sane person knowingly undergoes health care that is ineffective or harmful. But ineffective or harmful services are just as effective as necessary care in generating employment and incomes, thus adding to total. Furthermore, both effective and ineffective care may be provided at different levels of technical efficiency. One country may spend more, not because it is getting more health benefits, or even more health care, but simply because its institutions for providing care are less efficient and more wasteful of human and physical resources.

Those who argue the inevitability of rationing must necessarily assume away the existence, on any significant scale, of either inefficient or ineffective care -- and they do. They thus slide smoothly past a large and steadily growing body of contrary evidence -- in effect ignoring what they cannot refute. But if the "rationing" story in health care is, at its core, not an intellectual investigation but rather part of a propaganda campaign to try to secure more resources and incomes for the health care sector, there is no reason to expect its advocates to take account of the now overwhelming (at least in the United States) contrary evidence.

"It is foolish to believe that increases in health care inputs and throughputs lead to increases in health status outcomes" (Maynard (1981, p.145). But it is not at all foolish to try to persuade others to this belief, if one can thereby enhance the willingness to pay for one's own services, and avoid awkward questions.

The spectre of "rationing" may possibly become reality at some time in the indefinite future. But it is not now, and may never be, in any of the wealthier industrialized countries. There is, at present, no direct linkage between levels of expenditure on health care, and the achievement of health outcomes, in any health care system in the industrialized world (Mackenbach, 1991). We are all a long way from the grim trade-off of "Your money or your life".

ii. Less for Some, More for Others; The Oregon Experience

Indeed the highly publicized efforts by the legislature of the state of Oregon to establish explicit rationing criteria for Medicaid services, and to deny funding for certain life-prolonging but very expensive procedures, illustrate precisely what is really at issue in the "rationing" debate. In the first place, these efforts were not motivated by resource constraints in Oregon, much less in the United States system as a whole. Rather they expressed the unwillingness of the better-off majority of the population to contribute more to the care of people in the lowest income groups. What was "rationed" was willingness to pay -- for others.

Secondly, such explicit rationing for a particular sub-group can coexist with over-funding and over-provision for other segments of the population -- and apparently did in Oregon. Fisher *et al.*, (1992) demonstrated that if discretionary hospital admissions in high-use areas could be brought down to the levels found in other parts of the state, enough money could be saved that there would be no need to ration Medicaid services. Apparently inappropriate -- unnecessary -- hospital use by the general population was being left untouched, while specific services were being denied, "rationed", for those dependent on Medicaid.¹¹

¹¹. Note the parallel of interests between the "expansionists" and the decriers of "rationing". When explicit rationing *was* attempted in Oregon, it was applied to the politically and economically weakest in the population, without raising any awkward questions about how effectively the health care system itself was functioning. Since, by assumption, that system is already both efficient and effective, what point would there be to such questions? And since we cannot do everything for everybody, we are with deep regret and much soul-searching forced to do less -- for someone else. Meanwhile the health care system as a whole expands along its merry way.

The assumption that all care currently being provided is effective, and that any reductions must represent a threat to health, is not taken seriously by any student of health services in any country, least of all in the United States. But the spectre of "rationing" plays the very important political role of diverting public attention from the question of whether the services now being provided, are effective and appropriate. Instead we are led back into the familiar bog: "How else will we meet the needs? We must have more money!"

iii. Paying for More Care, or Just Paying Higher Prices?

But a moment's reflection should also remind us that more money does not necessarily buy more services, effective or otherwise. It may simply support higher prices. This point emerged very clearly from an analysis of OECD data by Gerdtham and Jönsson (1991b), in which they were able to identify the extent to which differences among countries in health care costs were a result, not of differences in levels of care, but simply of differences in the *relative* prices of health care services, from one country to another.

Gerdtham and Jönsson began by converting health care expenditures *per capita* in each of the OECD countries from domestic currency into US dollars. Typically this is done using purchasing power parities (PPPs) rather than exchange rates.¹² When PPPs are based on comparisons of the relative prices of all the commodities in the GDP, one finds very large differences between *per capita* spending in the United States, and in all other countries. Americans, at the time of this analysis, were spending about 50% more than the next two most expensive countries, Canada and Switzerland, 75% more than France and Germany, and more than twice as much as any of the rest.

But if instead one converts other countries' currency into US dollars using PPPs specific to the health care sector, Gerdtham and Jönsson found that much of this differential disappeared. In this alternative comparison, Canada spent as much *per capita* as the U.S., Japan spent almost as much, and Sweden spent substantially more. Every country in the OECD moves up relative to the United States, some by a small amount and others by a great deal.

This finding implies that a large part of the differential is due to higher relative prices of health care in the United States, not to higher levels of services. It is not just that prices for health care goods and services were higher in the United States than elsewhere. They were; but the point is that the *ratio* of health care prices to the general price level was also much higher in the United States than in other countries. Americans received on average (at that time), no more care than Canadians, very little more than Japanese, and much less than Swedes. But they paid much more, relatively, for what they got. In terms of the identity above, P (the Price) is higher in the U.S. than anywhere else.

Other studies support this inference. Schieber *et al.* (1994) also show significantly higher rates of relative inflation of health sector prices in the U.S. than in other OECD countries. Several comparisons of the Canadian and American health care systems have shown rates of service use that are on average very similar, with Canadians receiving more of some forms of care, and less of others (Fuchs and Hahn, 1990; Nair *et al.*, 1992; Redelmeier and Fuchs, 1993). Most recently Anderson *et al.* (2003, 2005) have reached the same conclusion from the OECD data.

¹². These are less volatile than exchange rates, not being sensitive to the effects of short-term capital movements. They attempt to compare the relative costs of similar baskets of commodities in each country.

More narrowly focused, but with by far the best comparative data, is a recent study of costs of coronary artery bypass grafting in hospitals in Canada and in the United States that all employ a common accounting system (Eisenberg *et al.*, 2005). Using chart review, the researchers were able to identify patient characteristics and outcomes, and to calculate within a similar accounting system the costs of comparable cases. Outcomes for comparable cases were the same on both sides of the border, but in-hospital costs per case in the United States were nearly twice those in Canada. Why do Americans spend so much more for health care? "It's the prices, stupid!" (Anderson *et al.*, 2003).

Why should care be so much more expensive in the U.S.? Apologists for the current system either avoid the question entirely, or try to argue that the quantity comparisons are invalid. Americans pay more because they get higher "quality". But this alleged higher quality is not reflected in better outcomes, or better population health status, or even greater public satisfaction. So what is it?

Apologists trained in economics may then shift into theological arguments that reduce in essence to such comments as: "The quality *must* be higher, or else rational patients making informed choices in free markets would not have paid for it. Objective data are irrelevant; it is [my] *theory* that must be decisive." And so it may be, in some world far from the one we actually live in. Those whose religious faith is weaker refer instead to the excellence of the care received and the outcomes achieved by *some* Americans -- and nobody can deny that these are indeed excellent. But systems must be judged on their overall performance, bad as well as good, and it is hard to find there any justification for higher prices in the United States. In any case Eisenberg *et al.* (op. cit.) find no evidence of quality differentials between procedures in the United States and Canada, despite the dramatic difference in expenditures.

iv. Bargaining Over Incomes - How Much Are Providers Worth?

High prices have two possible sources, high incomes and low efficiency. Comparative price data show the powerful effect of these factors taken together, but do not disentangle them.

Taking the first point first, much of health policy is taken up with, in Reinhardt's (1987) phrase, "the allocation of life-styles to providers". How much shall providers earn, relative to the rest of the community, or more generally how shall this be decided? Although this is obviously a critical factor in determining the costs of health care, it is not one that health care providers typically wish to discuss explicitly -- at least not the highest-earning ones. They would rather talk about unmet needs, and the escalating costs of providing quality care.

In a competitive marketplace, relative incomes are determined by "demand and supply" and are not amenable to political bargaining. In the real world of health care, however, the boundaries set by market forces tend to be broad and indistinct, and to leave a wide band of discretion. International comparisons of physicians' incomes, for example, show that their skills and long education periods lead to correspondingly high incomes everywhere, just as "demand and supply" would predict. But the size of their income advantage relative to the rest of the community is highly variable, both from country to country, and over time within countries. It is relatively low in the Nordic countries, and particularly high in the United States. Physicians were in the past very well off in both Germany and Canada, but have lost some ground (in Germany quite a lot) relative to the general income level (OECD, 1987, p.76; Gerdtham and Jönsson, 1991a; Groenewegen *et al.*, 1991; Fein, 1992).

Much less attention has been given to international comparisons of incomes for other classes of health care personnel. Redelmeier and Fuchs (1993), however, found that overall, the average rates of income of hospital workers were very similar in Canada and in the United States -- about 4% higher in the U.S. But the wages of more highly skilled workers -- head and general duty nurses -- were about 20% higher in the

U.S., while wages of housekeepers and aides were about 20% lower. This may well reflect the greater role of unions in Canadian hospitals; if so European countries may show patterns more similar to that in Canada.

The point for our purposes, however, is simply to emphasize the variability in worker incomes in the health care sector, across countries and over time, relative to the rest of the community. They are not dictated by "the market"; institutional environments matter. Accordingly efforts by payers to control rates of pay -- wages, salaries, fees, and prices -- in the face of counter-pressures from providers, make up a large part of the process of cost containment in national health care systems. The political dimension of this process of bargaining over provider incomes is quite overt, in negotiations over the level of fees or salaries that will be paid by public or quasi-public insurers, and over the opportunities which physicians in particular will or will not have to increase their incomes by charging patients directly.

The process of bargaining over provider incomes varies with the structure of the delivery system in each country. In a number of countries physicians may be independent practitioners who are paid by fees for service. In Canada this is true of both generalists and specialists; in several of the European countries specialists may be hospital-based and on salary.¹³ Most other health workers are salaried employees of hospitals or clinics that are themselves typically funded through some form of budgetary process. As a general observation, however, bargaining tends to evolve from specific items to more comprehensive budgets.

One may begin by negotiating fees with physicians. But payers rapidly discover that, depending upon the rules for payment, the total volume of billings per physician can be quite elastic. Hillman *et al.* (1990) provide a particularly dramatic example.¹⁴ Which items are in the fee schedule -- does it cover all diagnostic tests, for example? -- and who can be reimbursed for particular services -- all practitioners, or only selected ones? -- may be as important for the evolution of total costs, as the actual level of fees.

The same problem emerges for pharmaceuticals, where again prescriptions are typically reimbursed on an item of service basis. The price of any given drug may be stable or falling over time, but the constant introduction of "new" drugs, real or apparent, keeps increasing both the number of prescriptions per capita and the average price per scrip.

Indeed the pharmaceutical industry provides the most naked examples of efforts by providers -- the pharmaceutical manufacturing industry or "Big Pharma" -- to manipulate the regulatory process in order to inflate costs, *i.e.* industry revenues. The strategy is two-pronged; the regulatory process is infiltrated and used to suppress competitive market forces and prevent the emergence of anything resembling price competition for prescription drugs, while at the same time undermining any efforts to regulate prices or industry incomes. It has been remarkably successful; pharmaceutical costs are the fastest growing component of health care costs in all developed countries despite growing evidence of inappropriate prescribing and excessive pricing.

Perhaps the most breathtaking example is that of (former) Representative Billy Tauzin, "a principal

¹³. But if salaried practitioners are also permitted to engage in some level of private fee practice, the level of effort (not devoted to the salaried service and the steering of patients toward more remunerative private care become continuing problems that seem beyond the reach of negotiation or monitoring.

¹⁴. They found that, for patients with clinically equivalent problems, physicians who owned their own diagnostic radiology facilities took on average *four times* as many films, and charged forty percent more, for a total cost over six times higher, than physicians who referred to arm's-length radiologists. Such observations rather undercut the claim that the volume of services provided is simply a response to patient needs -- or for that matter, demands.

architect of the new Medicare drug law”, who then resigned to “become president of the Pharmaceutical Research and Manufacturers of America, the chief lobby for brand-name drug companies” at a salary estimated at about \$2 million a year (Pear, 2004). Tauzin’s services to the industry? “The law steers clear of price controls and price regulation... [and] forbids the government to negotiate with drug manufacturers to secure lower prices for Medicare beneficiaries”.

Other countries have been somewhat more successful in imposing some institutional limits on the pharmaceutical industry’s ambitions, but in the present era the industry has been using its extraordinary influence in Washington to undermine those efforts through bilateral trade agreements between the United States and other governments. The industry’s agenda is front and centre, as it was in the case of the Medicare benefit law, with the United States government essentially acting as the industry’s agent abroad as well as at home.

More generally, the attempt to control provider incomes leads payers through increasing restrictions on service volumes, towards some form of global budget within which the negotiation of prices for individual items of service may continue. Physicians -- and drug companies -- respond by trying to open up or expand access to the private funds of patients. In a number of the OECD countries they are employing the currently fashionable rhetoric of the marketplace. But that rhetoric -- privatization, competition, efficiency, and so on -- is simply window dressing behind which providers are still following Wildavsky's Law. They are trying to keep expenditures on health care expanding, in the face of relatively successful (outside the United States) cost control in the public sector, by seeking other sources of funds to absorb.

In terms of the balancing identity, they are trying to expand the revenue side by increasing direct charges (C) and then private insurance (R) to compensate for the restrictions on public funding through various forms of taxes (T). This would then permit continuing increases in either or both of average prices (P) and volumes of services (Q), and correspondingly increased provider incomes. Demands for extra-billing, and for expanded private "markets" more generally, in all public systems of health care finance, are thus quite understandable attempts to subvert cost *containment*, which threatens provider incomes, and replace it with cost *shifting*, which does not.

Apart from the pharmaceutical benefit debacle, the United States Medicare system has moved quite rapidly through the common stages of fee negotiation, establishing a Resource-Based Relative Value Scale (fee schedule), and introducing measures both to encourage "assignment" (discourage extra-billing) and to discourage multiplication of services -- Volume Performance Standards.¹⁵

The result has been that over the long term, per enrollee cost has escalated less rapidly than in the private insurance sector (Boccuti and Moon, 2003). Between 1970 and 2000 per enrollee costs for comparable services rose at an average rate of 9.6% for Medicare and 11.1% in the private insurance sector. This relatively small annual advantage, less than 1.4% per year, cumulates over thirty years to about fifty percent. If Medicare’s control performance had been equivalent to that in the private sector, Medicare outlays per enrollee would have been fifty percent higher. Boccuti and Moon attribute the difference to “Medicare’s ability to price aggressively”. The pharmaceutical industry drew the same conclusions, and used its control of Congress to ensure that the drug benefit law, passed the next year, would forbid Medicare from using that ability.

¹⁵. There has always been a fee schedule for services paid by Medicaid, but this is generally viewed as "welfare medicine", outside the American mainstream. Not all practitioners accept Medicaid patients, because the fees are considerably lower than those of Medicare, let alone private insurance.

But the principal difficulty for cost control is that American Medicare operates alongside a private insurance system that has no such controls, and much less potential for introducing them. This alternative, uncontrolled "market" -- which is in reality quite unlike any normal market -- weakens the bargaining power of the public program. Accordingly one finds that although Medicare pays lower fees than private insurers, it still pays very high fees by international standards. Thus the preservation of private insurance has been of vital importance to physicians in maintaining their fees and incomes, even though it pays only one third of total health care costs.

In contrast physician incomes, and where relevant, fees, have been more or less restrained - though often with bruising political struggles - in most of the other countries of the OECD. More detailed comparisons with Canada have shown quite clearly that the centralization of bargaining over physicians' fees resulted in a slowing in the escalation both of fees, and of overall outlays on physicians' services (Barer *et al.*, 1988; Evans, 1987). This slowing is observed relative to both previous patterns in Canada, prior to the establishment of the public universal insurance plans, and contemporaneous experience in the United States. The private insurance sector in the United State has thus played precisely the "safety valve" role that Canadian physicians have identified for it in Canada -- a way of protecting their incomes in the public plan, and thus resisting cost containment.

v. "Interfering in the Practice of Medicine"

As noted above, health care -- or anything else -- can be expensive either because the people who produce it are paid a lot, or because they are not very productive. High levels of W (rates of payment), or of Z/Q (inputs per unit of output), are both reflected in higher prices P . The latter we may call technical inefficiency -- more resources than necessary used up in production. Such inefficiency can show up either in the provision of health care *per se*, or in the operation of the payment system. This section focuses on health care; the organization of the payment process will be considered later.

Traditionally the payers for care, whether public or private, have avoided "interfering in the practice of medicine". They have not enquired into the details of servicing patterns, or how or why providers made their diagnostic and therapeutic decisions. Political and administrative negotiations or conflicts have focused on financial issues -- fees, salaries and budgets.

Payers in virtually every country have also tried to exert some control over the total capacity in the health care system, particularly hospital and major equipment capacity. There is general understanding that utilization of health care is predominantly capacity-driven, heavily influenced by the availability of facilities and personnel, independent of the "needs" (however defined) of the populations served.

Capacity control contributes to, but is not sufficient for, overall cost control, as American health planners have learned long ago. Culyer (1988) argues that Canada and the European countries have been more successful because they have also placed global restraints on total financing rather than relying only on controls of "demand", "supply", or capacity.

Such global controls leave the maximum scope for provider autonomy within the overall physical and financial limits. The process of determining those limits, however, becomes rather arbitrary. Providers can always allege that the limits are too tight, and that serious needs are going unmet - people dying on the waiting lists. Payers counter with the rhetoric of cost explosions - more than the country can afford. The general public, in its various roles as actual or potential patient, taxpayer, or voter, is unlikely to find the facts of the case significantly clarified by either side.

For decades, however, researchers have been observing that there are large and unexplained variations among patterns of practice and servicing rates – differences among countries, and among regions in the same country, and among individual practitioners -- which seem to bear no identifiable relation to the needs of the populations served (Lewis, 1969; Bunker, 1970; Vayda, 1973; McPherson *et al.*, 1982; Roos *et al.*, 1986; Chassin *et al.*, 1986; Ham, 1988, and many more). These variations show up in the fine structure of care - in particular procedures, not just aggregate utilization rates.¹⁶

At the same time, a considerable proportion of diagnostic and therapeutic interventions are carried on in the absence of any scientific evidence that they actually benefit patients, and in a non-trivial number of cases have been shown to do actual harm. A still more important problem, quantitatively, are those interventions which have been shown to benefit certain patients with particular conditions, but which are offered to a much wider range of patients for whom no such evidence is available (Banta *et al.*, 1981; Feeny *et al.*, 1986). This is a particularly serious problem with pharmaceuticals, since the typically very large margins between prices and costs of production create powerful incentives for maximum sales efforts, and generate the resources to support them.

The widely documented variations in patterns of health care, now stretching back over nearly forty years, have for an equally long period been noted and then ignored. The typical response is some combination of undocumented claims that variations correspond to differences in patient needs, and when no such differences are found, some variant of “But who knows which rate is right?” Business continues as usual. But a group of researchers at Dartmouth University, under the leadership of John Wennberg, have been doggedly pursuing evidence on that question, and have begun to report findings that tie variations in health outcomes directly to variations in practice patterns.

In a series of related studies of particular procedures in the Medicare population, Fisher *et al.* (2003a, 2003b) have now shown not only that there is wide variation in patterns of utilization and cost per enrollee across hospital service areas in the United States, but that mortality is actually *higher* in the high service, high cost areas, while satisfaction levels are essentially similar. Regional populations are adjusted for age, sex, and (proxy) measures of health status. Higher rates of care use are in large part associated with higher levels of hospital and specialist availability, but the additional care does not simply add nothing to health, it is actually a threat to health. These findings have not been successfully challenged, but in the conventional rhetoric about rising needs and demands they are simply ignored.

On the same theme, Baicker and Chandra (2004) report that when states are ranked on their scores on a widely accepted measure of the quality of medical care, there is a strong *negative* correlation between cost per Medicare enrollee, and also availability of specialists, and quality of care so measured. (The availability of general practitioners, however, is positively correlated with quality rankings.) The evidence is increasingly solid that higher costs, at least in the United States, are associated not with better quality of care, but with worse.

Such findings confirm long-standing suspicions that there is a huge potential, especially in the United States, for containing or reducing health care costs, with no harm or even benefit to patients. There is NO evidentiary basis for claims of the “Painful Prescription” variety, and much to show that the health care system of the United States is simply grossly over-funded for the work it does, and even more for what it should be doing. There is no need to “ration” access to effective care, and rationing of ineffective care is a solution, not a problem.

¹⁶ The distinction between inefficient production, and ineffective care, becomes fuzzy here. If a stay in hospital is unnecessarily prolonged, is this the inefficient production of an episode of care, or the production of ineffective hospital days? At the most aggregated level, all ineffective care represents the inefficient production of health.

Realization of this potential depends, however, on improving the management of the health care system. More specifically, the system must be managed explicitly to achieve health outcomes, and to identify and eliminate ineffective and wasteful practices and procedures, rather than just to sustain traditional practices and to add whatever other new ideas attract the attention of clinicians (Wennberg, 1984, 1988).

This realization had begun to sink in quite widely nearly twenty years ago and to emerge in serious political debate (The Economist, 1988; Roper *et al.*, 1988; Andersen and Mooney, 1989). But the collapse of the Clinton national health insurance plan led to abdication by the federal government, and widespread embrace of the ideologically more comfortable faith that somehow the private business sector would be capable of managing health care for better outcomes and lower costs. The broad popularity of the idea of private "managed care" should have been a warning that it was unlikely to result in effective cost control.¹⁷

The principal reason for political reluctance, in virtually all countries, to tackle this issue, is that such management directly challenges the professional prerogatives of providers. Practitioners everywhere have always insisted that the "best" medicine was practiced by trained and experienced clinicians relying on their own individual clinical judgement. This is an article of faith, unshaken by observations of wide variations in clinical practice, or examples of clinical practices unsupported by and even in defiance of experimental evidence. The threat of accountability to others, who may draw on statistical and experimental evidence in evaluating and even directing their performance, strikes directly at professional autonomy. It is likely to excite even more severe political counterattacks than attempts at economic control, and may elicit substantially less support among the general public.

"Cost control" and fee/income bargaining seem to be viewed by the public, in most countries, as legitimate roles for payers. But it is not clear whether there would be political support for more detailed intrusion into the way care is provided. Even if there is widespread and very solid evidence – and there is -- that a great deal of inappropriate and unnecessary care is being provided, members of the general public are not familiar with that evidence. As users of that care, they believe their needs are being met.

Thus it is probably not accidental that it is only in the United States that the political debate has most clearly turned to the evidence of specific inefficiencies in the provision of health care, and the need for detailed utilization review (Roper *et al.*, 1988). Other countries have managed to contain their overall costs at an acceptable level, without taking on the political dangers inherent in appearing to attack professional autonomy. But the United States has thus far completely failed to achieve such control, while simultaneously failing to provide adequate coverage for its population. There appears to be widespread and long-standing agreement among the American population that major reform is called for (Blendon, 1989), but as President Clinton discovered, no agreement at all on what form it should take.

Desperate times call for desperate measures. In these circumstances the United States has developed a high degree of sophistication in the technical aspects of health care management. The rapid spread of payer-enforced "guidelines" for patient treatment -- *de facto* constraints -- in the private sector amounts to precisely the direct "rationing" that Americans have been led to fear from state-financed systems. The ironic result has been that, in successfully fighting off "socialized medicine", American physicians have found themselves confronted with far more intrusion from payers than would be imaginable in any other country. And American patients find their choices of provider increasingly restricted, again in a way unlike any other national system.

This is not to say that providers are not restricted in other countries. Budgets are never large enough; there is never enough equipment, sufficiently up to date, or enough support staff, to do all the things physicians

¹⁷ In fairness, the aggregate cost trends of the mid-1990s gave some reason to hope that this might happen, though many observers of the industry remained skeptical. Since then, their skepticism has been amply justified.

would like to do -- especially if they are paid fees for their services. Canadian physicians feel particularly hard done by, as they compare themselves with their colleagues in the United States. But nowhere else do payers require physicians to justify and seek approval for their proposed care plans for individual patients, in order to ensure reimbursement. Payer-imposed guidelines constitute precisely the "cookbook medicine" that clinicians regard as unprofessional and dangerous for patients.

It is, of course, conceivable that if the guidelines were both valid and flexible, the care of patients could actually be improved. When there are wide variations in patterns of practice, it seems highly unlikely that *all* represent best practice -- that "everything is optimal in its own way". But the private agencies that develop and enforce guidelines are trying to limit their own outlays, not to reform the practice of medicine. What they want are defensibly cheaper patterns of care; there is no reason why these should necessarily be better for patients.

It may be that the vigilance - and economic and professional interests - of providers, combined with the natural emotional bias against those who "sacrifice lives for dollars", will provide sufficient check on the stinginess of payers to prevent patients from being put at risk. But there is no guarantee of this. There may be a real need for "political entrepreneurship" to design institutions and assemble coalitions capable of offsetting payer interests, as the balance of power swings in their direction. But the present political climate is not propitious.

In any case, there is as yet no indication that the rationing of care by private payers has had more than a temporary impact on the global problems of the American health care system -- uncontrolled costs, incomplete and inequitable coverage, and public dissatisfaction. There *have* been large changes in patterns of care, including major declines in the use of inpatient hospital care, over the last two decades. But any savings appear to have been absorbed in increased costs of management.

Planes of Cleavage II: How Do We Split the Bill?

Foreign experience indicates that these global problems can only be successfully addressed by coordinating the behaviour of payers, while making them politically accountable. Most other OECD countries have passed this stage, and have either a unitary payment system (the UK, Canada), or tight regulation and coordination of multiple payment agencies (Germany, France). That unity or coordination, however, is not a once-for-all achievement. It must be maintained in the face of continuing pressures from providers who recognize very clearly the connection between "sole source funding" and overall cost control -- and who reject both. In the debates over "privatization" in Canada and Western Europe, providers have always been quite explicit in their attempts to expand the flow of resources to allegedly "underfunded" health care systems by diversifying the sources of funding (Weller and Manga, 1983).

The assembly or maintenance of payer coalitions is made difficult not only by the efforts of providers, but also by the natural conflicts of interest among payers for and users of services. However a society determines the share of its economic resources to be given to the providers of care, it must still allocate that burden among its various members. At the same time, the terms and conditions of access to the health care goods and services provided, *i.e.* "Who gets what, when and how", will also depend on the structural and administrative framework.

As noted above, in a tax-financed system the distribution of economic burden is related to ability to pay, with the closeness of the relationship depending on the overall tax structure. Taxes on income tend to be roughly proportional to incomes, or even somewhat progressive, *i.e.*, taking a larger share of income from those with higher incomes. Sales or consumption taxes are generally regressive, taking a larger share of the incomes of people with lower incomes and resting more lightly on the better off. Payroll taxes or "social

insurance" premiums result in a more regressive distribution of burden, particularly if there is a ceiling for individual contributions. But in any case an individual's share of total health care costs does not depend on his/her health status.¹⁸

Private insurance systems, by contrast, set premiums on the basis of expected claims, as indicated by past experience. Elderly people or those with chronic illnesses will carry a larger share of health expenditures, in the form of significantly higher premiums for coverage. Competition among insurers dictates this result; a company that tried to cover all comers at the same premium ("community rating") would find that it attracted all the worst risks.¹⁹ Direct charges to patients distribute costs according to actual illness/care experience, rather than prior expectation of expense. Which pattern of distribution is "fairer" is a political value judgement. As an empirical matter there does appear to be a broad consensus that people *should* contribute to the cost of health care in proportion to their ability to pay, and should receive care according to their needs (van Doorslaer *et al.*, 1993).

Illness and income are everywhere negatively correlated, though the strength of the correlation varies across countries. A truly private financing system would thus assign the largest share of cost to those with the least resources as well as the greatest needs. But it is manifestly impossible to finance a modern health care system solely on the basis of such a distribution. The unhealthy and unwealthy would simply not get care at all. The use of health care is highly concentrated on a small proportion of the population, who are predominantly elderly and/or chronically ill.

Berk and Monheit (1992), for example, found that among the non-institutionalized U.S. population in 1987, the highest-using 1% accounted for 30% of all health expenditures, while the top 10% accounted for 72% of costs. The lowest-using half of the population, on the other hand, accounted for only 3%. Forget *et al.* (2002) found very similar results ten years later for physician and hospital services used by the population of Manitoba population; over the period 1997-1999. The highest-using 1% of the population accounted for 26% of expenditures, and the lowest half accounted for 4%. Analysis by age strata did not change this pattern.²⁰

Hence the universal predominance of public payment, even in the United States. Unless a new political consensus emerges that would simply exclude a significant proportion of the population from access to health care, it is hard to see how that predominance could be challenged. On the other hand, the fact that *at any one point in time* a majority of the population is very little touched by health care costs, means that most people would not immediately be hurt by a reduction in public funding. Some would be hurt a great deal, but they are a minority.

Maintenance of the political consensus for public payment thus depends on a combination of a sense of solidarity with the less fortunate, and a prudential realization that most of us *will* become old, if we are not already, and many of us, or those close to us, will develop chronic illnesses. Only the very well off can be confident that they will never need some form of collective support, and that they can afford top priority in a private system. For them, shrinking the public sector is a rational agenda. But it follows that that

¹⁸. Of course total financial outlays are only one component of cost. Being ill or injured is a significant burden in itself; it may also result in loss of income and/or other additions to living expenses. The direct burden is inevitably borne by the patient; other economic losses are at best partially compensated.

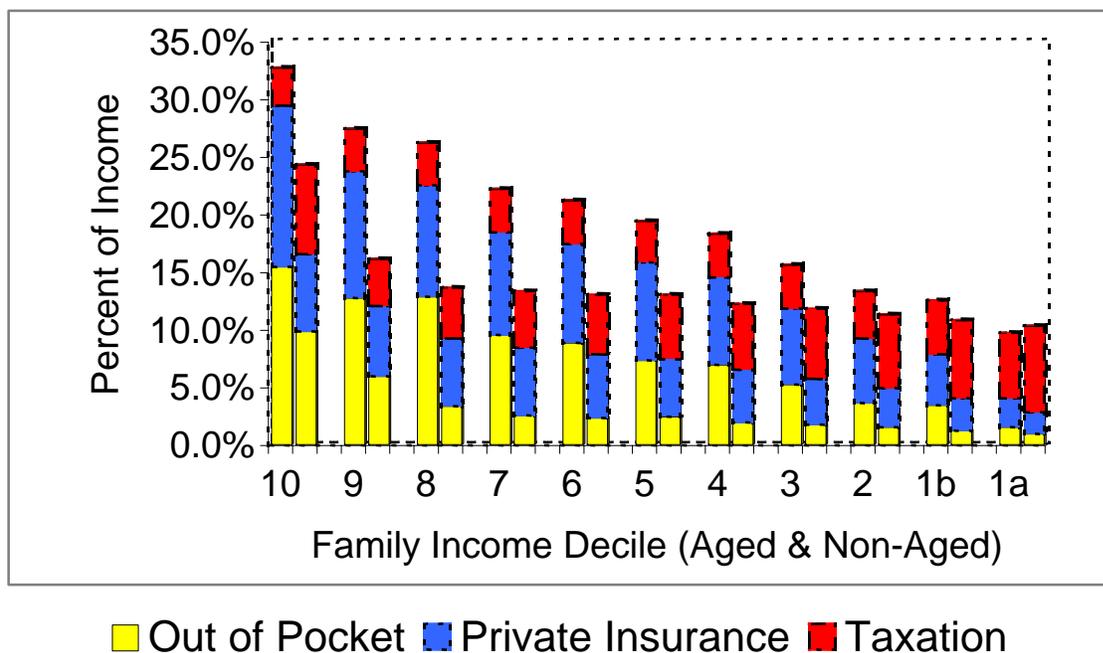
¹⁹. The non-profit "Blue" plans in the United States began in the 1930s by community rating, with exactly this result. Competition from the for-profit sector forced a shift to experience rating, or charging different premiums to different groups on the basis of estimated risk (Fein, 1986).

²⁰ It is important to appreciate that this heavy concentration of costs does not represent a random distribution of misfortune. The heavy users are typically carrying a long-term burden of illness.

political consensus is threatened by both increasing inequality of wealth and ever-escalating health costs – precisely the current trends in the United States.

In most countries, individual contributions to collective financing are simply detached from health status. The United States, however, provides public programs for those with the greatest needs and least resources (Medicare and Medicaid), and public subsidies (through income tax exemptions) for the private insurance system. The resulting distribution of burden is shown in Figure II, drawn from Rasell *et al.* (1993). In total, health expenditures in the United States take a much smaller share of income from the highest income groups than from the lowest, even though higher income people contribute a substantially larger amount per capita.²¹ The key observation, however, is that private insurance and self-payment have very similar distributions of burden -- highly regressive -- while tax-financed health spending is actually mildly progressive.

FIGURE 2: Share of Income Spent on Health Care, United States (1987), by Family Income Decile and Payment Form



²¹ Families in the top 5% of the income distribution contributed \$13,234 to health care in 1987, but this was only 10.2% of their incomes, while the \$960 contributed by families in the lowest decile was 26.9% of their much smaller incomes. Taxation to support health care funded through the public sector accounted for most of the difference in dollar amounts. The top 5% contributed \$9,650 in taxes or 7.3% of their incomes; the bottom 10% were taxed only \$214 per family or 6.8% of income. But their average payment of \$746 for insurance and direct charges was 20.2% of income, compared with the 3% (\$3,584) paid out by the 5% of families at the top (Rasell *et al.*, 1993, Table 1).

This observation frames the debate over the appropriate roles of user charges and private insurance. Shifting costs from public to private budgets, implies shifting them down the income distribution, and conversely. How White's (*op. cit.*) shared savings are assembled determines, to a considerable extent, what share each of us must contribute. Thus the endless debates, in every country, over the "public-private" mix of financing, are largely about how to shift the cost of care onto someone else. They never end, because they emerge from real conflicts of economic interest between the healthy and wealthy on the one hand, and the unhealthy and unwealthy on the other. Such conflicts cannot be resolved by "fact and argument".

But these struggles divert attention from the primary questions of how much to spend, and on what. It is as if a group of diners at a restaurant, greatly disturbed at the size of their total bill, and very suspicious about its contents, nevertheless spend all their energy debating who was to pay what share, rather than calling in the manager to demand an accounting for the overall cost.

Needless to say, the restaurant manager would prefer that the guests argue among themselves, rather than presenting him with a united front and demanding that he justify, and lower, his charges. The simplest summary explanation for the failure of cost control in the United States is that the institutional framework of health finance makes it easy and natural for the payers to try to pass the costs on to someone else, and very difficult for them to confront providers directly.

The intellectual framework provided by the rhetoric of the marketplace also tends to focus attention on the distribution among payers. The American economic literature perpetuates endless discussion of "deterrent charges", and the almost universal conviction that cost escalation results from low or zero "prices" to "consumers" at point of service, in spite of the obvious counter-examples in the rest of the world. Thus efforts by employers to shift the burden of health care costs to their workers - an understandable but unhelpful response to unchecked escalation - are applauded as "welfare-improving" despite their obvious lack of effect on overall costs (Manning *et al.*, 1987).²²

Tax-financed systems, in which the principle of universal coverage has long been accepted, are less vulnerable to these diversions. They do, however, show increasing conflict over access to care. If the community as payer controls outlays by limiting its overall "willingness-to-pay", there will remain individuals who, perhaps encouraged by their physicians, want more. Or they may want care on more favorable terms, *e.g.* shorter waiting lists, more convenient bookings, nicer surroundings. Pressure from unsatisfied users generates cleavages of two kinds, between users and payers, and among users themselves.

The split between users and payers is quite straight-forward. As noted above, payers are ultimately responsible to some user constituency, whether it be voters, premium-payers, or employees. (In the final analysis, in a democratic society, they are always responsible to voters.) If the relevant constituency comes to believe that payers' efforts to contain cost escalation are threatening their own health, the controls will fail.

A delicate balance must thus be maintained between the voter-as-payer and the voter-as-(actual or potential) patient. Much of the political activity by both payers and providers is intended to elicit from voters the identification favorable to their cause. People who think of themselves as actual or potential patients are likely to support increased health care spending; people who think of themselves as taxpayers

²² There is also a very strong ideological component to the conflict among payers and users (Weller and Manga, *op.cit.*). Since illness is inversely correlated with social class, whether measured by income, or education, or looser measures of status, the detachment of economic burden from either actual or expected illness results in a corresponding redistribution of income from higher to lower levels in the social hierarchy. To some this egalitarian effect is offensive *per se*, even if it is associated with a lower overall burden of expenditures.

or premium-payers are more likely to support efforts to control costs. The pharmaceutical industry provides, as usual, the clearest example, spending billions on advertising and lobbying, and the subversion of individual physicians, researchers, politicians, and even economists (Pear, 2003) to convince Americans, their physicians, and their political representatives that the extraordinarily high costs of drugs in the United States are justified by an ever-larger flow of health benefits.

But the more contentious question concerns the treatment of those who want more services, even though there is a well-established political consensus for restraint. Should they be able to pay for more timely or perceived higher quality services, within or separately from the collective system? The affirmative argument is usually presented as an alleged "natural" right to spend one's own resources as one sees fit, spiced with anecdotes of patients dying for lack of care. But the issue is, in reality, rather different. Very few people are really willing or able to cover the full costs of medical care for serious illness out of their own pockets, so there is very little demand, in any country, for a truly private, parallel system of care in which neither providers nor patients receive any direct or indirect support from the public sector.

Rather, those who are relatively healthy and wealthy tend to favour "moderate" deterrent charges or co-payments to restrict access by those with lower incomes, or the right to "go private" – in effect buying their way to the front of any queue by a relatively small extra payment.

Many providers, of course, would be only too pleased to enhance their incomes by charging additional amounts for preferential treatment, as has been the practice in the U.K. for years. Very few providers, if any, imagine that they could survive in a system where more than a small minority of users had to pay the full cost of their own care. But a "multi-class" system not only enables providers to charge extra for preferred access to care which is predominantly collectively financed, it also permits them to "whipsaw" payers and undermine global restraints by selectively withholding services from the patients of a particular payer, as American physicians do when they refuse to take Medicaid patients. Multiple income sources give one a stronger bargaining position. A perception that those who pay a bit extra are getting *therapeutically* superior care, *i.e.* better outcomes, not just better amenities, will in a democratic society eventually lead to extra payments for everybody.

All such discussion sidesteps the more fundamental issue of whether the services currently provided are medically necessary, or efficiently produced. As noted, there is substantial evidence that the short answer is "No", and that even the health care systems of Canada and Western Europe are in fact over-funded. In these circumstances, further expenditures whether individual or collective would seem ill-advised, to say the least.²³

But the spectre of "rationing", the threat that some will be denied "needed" services, is a very potent mechanism for undermining the unity of users. The least sick, and most well off, whether as voters or as patients, may be persuaded that they might fare better in a fragmented financing system with a greater element of user-pay.

And indeed some of them would. A shift from public to private funding definitely *will* move money, on average, from the less to the more wealthy as well as from the less to the more healthy -- that is the message of Figure II. The losers will be those, whether poor or moderately well off, who have the misfortune to become seriously ill. Providers who seek to fragment the sources of funding, and to increase the overall flow of funds by drawing in more private money, thus have natural allies in those towards the

²³ Rachlis and Kushner (1989) have written a comprehensive and very accessible survey of that evidence for the Canadian system. The western European systems show a similar pattern (Maynard, 1981; Enthoven, 1985; Culyer et al., 1988). Yet Canada and the major European nations spend between eight and ten percent of their national incomes on health care, while the United States spends over fifteen percent, and still rising.

top of the income distribution. The unique American outcome of uncontrolled overall costs and a highly regressive distribution of the burden of paying for those costs -- plus much better access for the wealthy and unhealthy -- reflects the success of this political coalition.

Planes of Cleavage III: How Many Spoons in the Dish?

The fragmentation of financing systems, under various justifications, is accordingly a common objective of providers the world over. They look for greater ability to negotiate increased resources from the rest of society, and to protect their own autonomy from external accountability. From a professional perspective, a multiplicity of funders with deep pockets and few questions represents the ideal environment both for doing good and for doing well. But can such conditions last? Again the United States experience is critical, though the results are not all in yet. Certain generalizations, however, seem secure.

First, economic success brings competitors. Large and rapidly growing pies attract others who would like to share. The normal reaction of a competitive marketplace to a "growth industry" is that new suppliers offer the same or better products at lower prices. The customer benefits from improved quality and falling costs -- consider *e.g.* the case of personal computers. But health care is not and never has been a competitive marketplace. The growth of the total revenues of the industry - health expenditures and incomes - has indeed drawn in new sharers, but the process and the results have been quite different from the predictions of hypothetical models of the competitive marketplace.

The first form of potential competition, starting in the 1960s, came from substitute personnel - nurse practitioners, midwives, dental therapists, chiropractors, denturists, *etc.* In some cases these practitioners could offer the same or better services at lower cost; in others the question of quality and servicing patterns was more open. But extensive research (*e.g.* Record, 1981; Spitzer, 1984) has left no room for doubt that, technically, such persons could significantly reduce the costs of health care services by substituting for the services of the higher-cost peak professionals, physicians and dentists.

But they would in the process also reduce the income streams of such personnel - the expenditure-income identity again. Accordingly during the 1970s professionals in all countries, including the "highly competitive" United States, used their political control of the self-regulatory process to suppress the development and deployment of their potential competitors. New forms of practitioners did emerge, but only under the economic control of the established professions. A potentially significant form of inter-provider conflict was thus strangled at birth. The victory of the peak professionals was swift and complete (Spitzer, 1984).

Learning from this experience, alternative practitioners have in subsequent years tried to present themselves as complementary to rather than substitutes for the established professions. They offer new and different product lines, thus trying to add to the total flow of income, and expenditures, rather than competing for a share of the existing flow. But it is pretty obvious to payers that adding still more income claimants -- increasing the factor inputs (*Z*) in the balancing identity -- is unlikely to mitigate cost pressures.

Lawyers, on the other hand, have in the United States been relatively successful in appropriating a share of the gross revenues of the health care system, through malpractice litigation.²⁴ In terms of the overall

²⁴ The lawyer's fees are paid from the plaintiff's award, which is paid by the malpractice insurer, who in turn collects a share of the physician's gross receipts as malpractice premiums. The physician passes on this cost in higher fees, and/or increased rates of servicing, to the patient or the patient's insurer. The latter, government or employer, passes the cost to taxpayers or customers. At no point is there an agency with the authority or the incentive to control the process.

identity, the prices P of health services are increased to cover the costs of legal services -- both plaintiffs and defendants -- used up in association with health care delivery and paid for from health budgets. Lawyers have inserted themselves among the Z , raising the Z/Q ratio.

Physicians tend to be particularly bitter about this incursion, and commonly attribute rising health care costs to the pressures placed on them by the tort system.²⁵ The direct costs of the tort system, however, as reflected in malpractice judgements and settlements, are in fact a small and stable share of overall health care costs (Chandra *et al.*, 2005). Lurid anecdotes about huge jury awards and the problems of particular specialties, regions, or individual practitioners grossly misrepresent the overall picture. The general rapid escalation of American health costs is drawing the cost of malpractice claims up with it. The claim that malpractice costs are responsible for that escalation is a myth.

Faced with such findings, clinicians often emphasize the addition to servicing made necessary by "defensive medicine", a cost allegedly several times greater than actual malpractice payments themselves. Such an argument implicitly concedes that a considerable proportion of servicing is "medically unnecessary", but shifts the blame from clinicians to lawyers. The solution to inappropriate care and escalating costs is.... tort reform!

But do those who make this argument, really believe that in the absence of the malpractice threat, rates of servicing -- and costs -- would fall sharply? How then would provider incomes be maintained, if they were not providing, and being paid for, the additional services which make up "defensive medicine"? In reality, the lawyers provide a justification for the increase in servicing, even as they skim off a (relatively small) share of the gross revenue and subject physicians to the miseries of litigation. Blaming the lawyers is simply another diversionary tactic to shift attention away from providers themselves.

The really serious economic challenge to clinicians, however, has arisen not from lawyers but from managers and marketers. By the end of the 1980s, payment administrators and system managers had in the United States become established as the most potent new competitor for a share of health budgets (Lee and Etheredge, 1989). They are impossible for providers to dislodge, because they have successfully integrated their services with the delivery and particularly the reimbursement of health care. Their relationship is not so much competitive as a complex combination of symbiosis and parasitism.

The fragmented funding system that prevents the containment of overall expenditures, also costs a great deal to administer. The difference between premium or tax payments to insurance agencies, public or private, and claims or benefits paid by such agencies, is an overhead cost of the payments system. It is the cost of marketing, premium setting and collection, and claims adjudication and payment, rather than of paying for services. Some such cost is unavoidable; complex institutions are not self-administering and would simply collapse without these services. But these costs are much larger in the United States than anywhere else for which data is available, and the difference adds literally tens of billions of dollars to American health care costs. Moreover they have risen dramatically over the last three decades.

Corresponding to these costs of insurance and prepayment are the large and increasing administrative costs within physicians' offices, hospitals and other care institutions made necessary by the process of complying with an increasingly complex payment system. These internal costs, which are recorded as part of the cost of providing care but again are simply "paper-pushing", add further tens of billions to expense without corresponding benefit to patients.

²⁵. Hence the bumper sticker: "Support a lawyer; send your child to medical school." Defenders of the tort system argue that the increase in legal inputs "buys" an improvement in the quality of output, keeping doctors on their toes in a way that regulation -- especially self-regulation -- never could. But this argument appears to be largely a priori, presented by interested parties operating in a data-free environment.

The team of David Himmelstein and Steffie Woolhandler, and their colleagues have been tracking these costs in a series of papers dating back over twenty years (Himmelstein and Woolhandler, 1986; Woolhandler and Himmelstein, 1991; Himmelstein *et al.*, 1996; Woolhandler *et al.*, 2003). They estimate that by 1999, the *extra* administrative costs generated by the private insurance system -- in both payment agencies and provider institutions -- relative to the corresponding costs in a unitary, universal payment system (Canada) was \$209 billion, or seventeen percent of total U.S. health care expenditures (Woolhandler *et al.*, 2003). If this same ratio held in 2005, the excess cost – administrative waste – associated with the operations of the private health insurance system would be \$330 billion.

No other country incurs administrative costs on this scale. Indeed according to the World Health Organization (2004), no other country in the world spends as much on its entire health care system, as the United States spends to support the huge “private bureaucracy” (Reinhardt, 1988) required by its idiosyncratic system of health insurance. These excess administrative costs, by themselves, account for about half the cost difference between the United States and the next most expensive countries in the world – Switzerland, Germany, Canada, France. But while they amount to pure waste motion in the financing of health care, they also account for \$330 billion in incomes – wages and profits -- in the insurance industry itself, in the non-clinical divisions of health care organizations, and in the benefits departments of private corporations. As President Clinton learned, those incomes are very powerfully defended.

Some may question the identification of these extraordinary administrative costs as pure waste, noting that they support a much more elaborate and sophisticated systems of management than are found in any other country. This is undoubtedly true, but rather misses the point. When more activity is paid for, more activity occurs. But this extra administrative activity yields no benefits, relative to the much simpler and less costly systems in place in other countries. The American health care system is not more efficient or less costly, indeed quite the contrary, and Americans are neither healthier nor happier as a result of all this activity allegedly on their behalf. This is hardly surprising if, as noted above, the principal reason for America’s much higher expenditure on health care is the much higher prices.

It is also important to be clear that “waste” is defined from the aggregate, system-wide perspective. For the individual insurance company, hospital, or physician’s office, these expenditures are essential to continuing operations. But they are essential for each participant only in order to deal with the behaviour of other participants. They add nothing to, indeed detract from, the effectiveness of the system as a whole. In a more rational payment system, such as that in Canada, they vanish.

This massive bureaucracy has been built up over decades. “Between 1969 and 1999, the share of the U.S. health care labor force accounted for by administrative workers grew from 18.2 percent to 27.3 percent. In Canada, it grew from 16.0 percent in 1971 to 19.1 percent in 1996.” (Woolhandler *et al.*, 2003) And these data do not include insurance industry personnel. It is the product of a sort of “administrative arms race” between providers and payers in which insurers attempt to control their own liabilities by shifting costs onto others – by limiting what and whom they will reimburse. Providers, correspondingly, have had to add ever more layers of administration to get their bills paid.

In terms of the restaurant analogy, our embattled diners have each called in their own accountants and lawyers to help them minimize their share of the total bill. But the total cost of the meal is predictably escalating further, as it includes the payments to all these non-culinary personnel. The restaurant is becoming increasingly noisy and crowded, and the manager is becoming somewhat nervous. These new participants are disturbing the smooth functioning of the restaurant, and they do not order anything to eat! Furthermore, they are taking a share of his customers' money, threatening to reduce the amount available to pay his bill. So far, however, that does not seem to be happening, and he keeps on quietly padding the bill.

American providers have been caught in a dilemma. The financing system that by its diversity and complexity has protected them from external financial control is absorbing a larger and larger share of health system incomes just to keep it running. And to add insult to injury, pressures from payers have led to greatly increased attempts to influence the practice patterns of individual physicians. Physicians' autonomy is under threat from the payment system itself. Their former allies have become very expensive, and more aggressive in grabbing for the levers of power (Webber and Goldbeck, 1984; Roper *et al.*, *op.cit.*; Lee and Etheredge, *op. cit.*). Machiavelli would have appreciated the irony of the situation.

Conflict Management? Or Sauve Qui Peut?

The planes of cleavage described above are universal. The management of these fundamental conflicts of interest -- and particularly that between payers and providers -- makes up a large part of the politics of health care finance in all developed countries. In no system can the conflict be avoided, but how it is managed makes a great deal of difference both to the balance of gains and losses, and to the amount of "collateral damage" generated in the process.

All other high income countries have created collective institutions -- either public single-payer or publicly coordinated multiple-payer -- for negotiating between payers and providers. The United States is unique in that the conflict remains largely decentralized even though the financing is largely collective. The results are much more advantageous to providers, at least in total, but there is a remarkably high level of collateral damage in the form of administrative waste motion as well as major financial damage to patients caught in no-man's-land. As the experience of U.S. Medicare shows (Boccuti and Chandra, *op cit.*) Americans are perfectly capable of designing public payment systems that place some limits on cost escalation. But as the fate of the Clinton plan and the career of the egregious Billy Tauzin (Pear, 2004) demonstrate, providers are able to penetrate the political system and use the media to undermine this process or even foreclose the possibility.

The most striking features of the American health care system all arise from this decentralization and fragmentation of the payment process. Most obvious is the extraordinary level and apparently uncontrollable escalation of expenditures. Present projections are that by 2014, health spending will pass 18.7% of GDP. Second is the extraordinary proportion of this expenditure absorbed in administrative waste motion. This is in turn a partial explanation of a third feature -- the vastly higher American costs buy neither more care nor better health but merely support higher prices. And finally, a significant share of the non-elderly American population have grossly inadequate insurance coverage or simply none at all. This proportion, too, is projected to rise over the next few years.

The continuing cost escalation, however, will be the driver of future change. The majority of Americans can live with the problems of the uninsured, who are after all mostly other people. And those with insurance or private means appear to have been convinced that their extraordinary expenditures, while perhaps painful, are buying the "world's finest care" -- technological miracles every day. The reality, that hundreds of billions are being siphoned off in useless administrative paper-pushing, has not penetrated.

Indeed one could perhaps argue that the American system, massively expensive as it is, does exactly what the dominant groups in American society *want* it to do. Bearing in mind Marmor's paraphrase of Hegel; "Nothing that is regular, is stupid," critics of that system may simply be applying inappropriate criteria. Perhaps those Americans who matter do not *want* an efficient, effective, or -- heaven forbid! -- equitably financed system.

Perhaps they want a system that imposes no effective limits on the business opportunities of providers of care or support services, individual or increasingly corporate. That is the other side of the expenditure coin. Accepting uncritically the marketing message that “More (and more expensive) is better.” they want care unlimited in quantity or quality readily accessible at need -- to those able to pay. But they refuse to be taxed to pay the corresponding costs of those less fortunate.

Such a system inevitably provides access to care that is steeply graded by social class (e.g. Scott, 2005). Those at the top get the best care, easily accessible; those at the bottom are cared for, if at all, on terms that would be a political scandal in any other wealthy country. And the burden of payment will be distributed much more regressively than elsewhere – which is just fine, for those on top. If the result is greatly inflated costs and a grossly inefficient financing system, well, that is a price worth paying in order to avoid the more egalitarian outcomes of more efficient systems. Beyond rhetoric, America’s current leaders have no detectable concern for improving the efficiency or effectiveness of their health care system, much less for the health of the American population.

“That no one in the U.S. Congress shows much interest in the glaring inefficiencies that could easily be addressed within the current Medicare program speaks volumes about the true, but hidden, agenda that actually drives the quest for privatizing ... Crisply put, the objective is to shift responsibility for health spending on older persons from the general taxpayer onto the older people themselves...” (Reinhardt, 2001, p.201).

The various gimmicks being proposed for “reform” of America’s version of Medicare illustrate Reinhardt’s point. Medical Savings Accounts, Medicare + Choice, and the whole rhetoric of “consumer-directed health care”, are all marketing terms for plain old-fashioned user-pay – rolling back or even eliminating Medicare, shifting costs from taxpayers to users – and thus shifting the burden of payment down the income distribution and further steepening the gradient in access. “Consumers” are people with money. Sick people are patients.

At the same time the coverage of the employment-based private insurance system has begun to erode under the pressure of ever-rising costs. General Motors provides a dramatic symbol, as the “legacy costs” – pensions and health benefits for retirees – threaten to bankrupt one of the world’s greatest companies. Whether or not they do, post-retirement benefits are already being cut while current employees are facing an increasing share of health care costs. The relentless pressure of escalation leaves little choice.

The shifting of both public and private costs to users is encouraged by those American economists with the deeply held religious faith that insurance leads to “overuse”.²⁶ Requiring users to pay more of the costs of their own care will somehow improve the efficiency of the health care system and in any case will lead to lower costs. This faith, rooted not in economic analysis but in personal ideology, has for a generation defied the American and international experience. It serves to clutter and confuse the American policy debates, but in the now relatively naked contest of class interests the economist advocates of user-pay appear to be essentially cheerleaders rather than players.

While cost-shifting strategies are a popular response to cost escalation, there is no reason to believe that, even if successful, they will halt that escalation. So what next?

National health insurance, universal and single-payer (or coordinated multiple payers) remains the only known way of containing costs, but it seems at least as remote as ever in the American political context.

²⁶ It is critical to understand that this economic concept of “overuse” bears absolutely no relation to patient needs or the effectiveness or appropriateness of care. It is defined solely in terms of “willingness” – i.e. typically ability – to pay, and is thus a purely ideological concept. Economists, however, all too rarely make this clear.

Perhaps a dramatic loss of coverage over the next decade will produce a political earthquake, but present signs are hard to find. “Managed care” mechanisms appeared to yield a certain amount of success in the mid-1990s; perhaps they can be revived and adapted to make these more acceptable and effective (Schur *et al.*, 2004). Perhaps.²⁷

A very clear-eye view of the options emerges from a confidential memorandum drafted for the Board of Directors of Wal-Mart (Chambers, 2005; Greenhouse and Barbaro, 2005). The memorandum considers both variants on the “managed care” strategies -- steering employees (“associates” in Wal-Mart-speak) towards more conservative and less costly providers – and increases in deductibles and co-payments. But it concludes that while both should be expanded, neither approach is likely to have significant impact.

The memorandum then notes that, as in all populations, a high proportion of health care costs are generated by a relatively small proportion of employees. If one could identify these employees and find ways to outpace them, or better still to avoid hiring them in the first place, that *could* have a significant impact on Wal-Mart’s costs. Crudely put: “Dump the Dogs”.

This could work. And it is highly doubtful that Wal-Mart is the only American company to have thought of it. Why not? Private employers, like private insurers, are not charities. Employment-based coverage already excludes those with the highest risks – the elderly, the unemployable, the poor – leaving them for the public sector to cover. It is a logical extension of the basic principles of private insurance. What happens to those higher-risk people? Well, that is not Wal-Mart’s problem.²⁸

Perhaps government will step in again? The present American administration has for several years been weakening the fiscal position of the federal government – quite possibly deliberately -- through tax cuts and military spending. Large deficits have cumulated into a rising burden of public debt (relative to national income). Without tax increases there is little scope for increased public spending, even if the will were there.

If employers begin to follow the route suggested in the Wal-Mart memorandum, the high users may simply be pushed over to uninsured employment, or out of the workforce. The consequences are well-known – health care costs draining family savings, accumulating medical debt, and increasing difficulty of access to poorer quality care (Collins *et al.*, 2004). Solving the corporate cost problem by dumping the dogs will reduce access for precisely those who need care most, while transferring more of the financial burden onto the weaker shoulders (which may include state Medicaid programs). But at least it will finally moderate the cost escalation.

Or will it? No scenario is plausible that fails to consider the reaction of providers. [This has been the great, gaping flaw in discussions of the health care sector in the American economics literature.] If the Wal-Mart approach works, it will threaten the ever-growing revenues of the American health care industry. How will they react?

An emerging answer is suggested by “concierge” or “boutique” doctors, “who, in exchange for a yearly cash retainer, lavish time, phone calls and attention on patients, using the latest in electronic

²⁷ In considering the relative long-term prospects for either single-payer or managed care, it may be relevant that the payment systems in place in other countries have only two roles for private insurance, (i) much reduced, or (ii) none. Managed care offers a continuing and even expanded role (and revenue) for private insurers as system managers. Against this enormous advantage, the fact that it may not work is a trivial objection.

²⁸ We may anticipate some accompanying rhetoric about high-risk people having deserved their fate – obesity, smoking, etc. There may also be quietly increased interest in genetic testing.

communications to streamline their care.” (Zuger, 2005). The yearly cash retainers are set high enough that they represent “a huge increase in per-patient reimbursement [that] allows the patient loads to be kept low.” In short, concierge doctors – general practitioners and internists -- make much more money while seeing far fewer patients, but caring for them much more intensively. And wealthy patients are in fact delighted to pay what is for them a relatively small annual retainer for highly personalized care, including hands-on guidance through the jungle of the American medical system.

The “value-added” services offered by concierge care include “same-day or next-day appointments and 24-hour telephone access to the doctor” and at the high end “home visits, deliver[ing] medications and accompany[ing] patients on visits to other doctors.” These hardly seem like the most effective use of the physician’s time, but wealthy patients are willing to pay. Unwealthy patients, who do not pay the retainer, are someone else’s problem.

Without trying to speculate as to how large this particular market might become, one can easily see the general principle behind it – greatly enhanced revenue per patient. If insurance coverage shrinks, so does the revenue potential from those with lower incomes. In terms of the fundamental balancing equation above, if T and R begin to shrink, providers can maintain their incomes only by finding ways to increase C. And they will.

Those who can pay must be induced to pay more, by the offer of value-added services, where “value” is defined as anything they are willing to pay for. What forms these innovations will take is difficult to predict; markets are endlessly imaginative. (Regular and comprehensive diagnostic imaging as “preventive” screening – MRI for those willing to pay – appears to offer substantial opportunities.) But the combination of eroding insurance coverage -- public and private -- and continuing pressure to maintain provider revenues seem likely to drive an increasing separation between access and need.

As providers, like Willie Sutton, “go where the money is”, access to care will over time become increasingly determined by willingness/ability to pay, and less and less by actual need for care. This is, after all, the way normal markets work, and it is the pattern that many American economists have been advocating for a generation. It is not a healthy situation, certainly not for the unhealthy and unwealthy.

At least so go the current trends. The interesting question, however, is whether, as those in the middle income ranges become increasingly vulnerable while costs continue to escalate, an effective constituency finally emerges for major political change. But that is too far down the road to see at this point. For now, most Americans still seem willing to believe that they have the world’s finest health care. As James Thurber said:

“You can fool too many of the people, too much of the time.”

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