Cascade Policy Institute

First, Do No Harm

Why American Health Care Policy is Failing, and How to Fix It

by Randall J. Pozdena, PhD

October 2002

About the Author

Randall J. Pozdena, PhD. is a consulting economist in Portland, Oregon and Managing Director of ECONorthwest, an economics and finance consulting firm. He is also President of QuantEcon, Inc. and Flash Network Services, Inc., Oregon-based research and Internet technology firms.

Dr. Pozdena is an academic advisor to Cascade Policy Institute, and has authored previous Cascade reports on K-12 and higher education, Social Security, and Oregon government spending. The opinions expressed in this report are his own, and are not necessarily those of Cascade Policy Institute, its donors, or the firms named above.

Acknowledgments

Cascade Policy Institute extends its gratitude to the Pharmaceutical Research and Manufacturers Association and its member companies for partially funding the distribution of this independently written report.

About Cascade Policy Institute

Founded in 1991, Cascade Policy Institute is Oregon's premier policy research center. Cascade's mission is to explore and promote public policy alternatives that foster individual liberty, personal responsibility and economic opportunity. To that end the Institute publishes policy studies, provides public speakers, organizes community forums and sponsors educational programs. Focusing on state and local issues, Cascade offers practical, innovative solutions for policy makers, the media and concerned citizens.

Cascade Policy Institute is a tax-exempt educational organization as defined under IRS code 501(c)(3). Cascade neither solicits nor accepts government funding, and is supported by individual, foundation, and corporate contributions. Nothing appearing in this document is to be construed as necessarily representing the views of Cascade, or as an attempt to aid or hinder the passage of any bill before any legislative body.

The views expressed herein are the author's own.

Contents

Preface

Although the axiom "first, do no harm" does not actually appear in the Hippocratic Oath taken by physicians, the sentiment does. We all expect health care practitioners to follow it. At Cascade Policy Institute we wish public policy makers would also follow it.

In an ideal world the medical marketplace would work much like any other, satisfying the demands of consumers with little or no outside interference. However, the medical marketplace is far from ideal. Politics intervened in health care a long time ago, and the result has been serious harm to America's health care system.

With a belief that knowledge is power, both in medicine and public policy, Cascade Policy Institute is publishing *First, Do No Harm*, authored by one of Oregon's preeminent economists, Randall J. Pozdena, Ph.D.

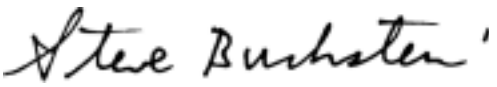
Dr. Pozdena begins his report with a brief history of American health care policy. He then describes in detail eight myths that policy makers and much of the public believe. Replacing these myths with their corresponding economic realities would go a long way toward restoring a health care marketplace that functions better for everyone.

Perhaps the most surprising part of *First, Do No Harm* is the author's contention that the fundamental fallacy of modern health care policy is the belief that Americans are underinsured, when in reality the opposite is true. Pozdena explains the risk-sharing purpose of insurance, and shows how the comprehensive insurance many of us have today actually helps *cause* problems such as high health care costs and lack of access by the poor. Once you grasp this counter-intuitive concept, you may never look at health insurance the same way again.

Just as important is the author's examination of the role that new drugs play in the health care marketplace. Closely examining the market for pharmaceuticals leads Pozdena to conclude that prescription drugs have been, and are likely to continue to be, *not the cause* of health care cost inflation, but its *salvation*. As with insurance, this concept is counter-intuitive, but very important to understand.

That this report originates in Oregon is no coincidence. This state has been considered an innovator with such efforts as The Oregon Health Plan, the nation's first explicit attempt to ration health care for the poor. Unfortunately, such innovation has failed, and has made the situation worse for many low-income people, and for the taxpayers who foot the bill.

First, Do No Harm is an important contribution to the health care policy debate in Oregon and across the country. We expect it to help lead the way to better public policy, so that all Americans can receive quality health care at affordable prices.



Steve Buckstein, President
Cascade Policy Institute

Introduction

It is obvious to most Americans that health care has become progressively more expensive and less accessible with each passing decade. Not surprisingly, politicians today are calling for aggressive reforms of the American health care industry. These include cries for universal, *single-payer* insurance coverage and for intervening further in the business of insurers, prescription drug manufacturers, hospitals and other providers.

There is great irony in this latest reform enthusiasm. It is relatively easy to show that it is not any fundamental flaw or "specialness" of medical care that is at the heart of health care woes; rather, it is six decades of poorly-crafted public policy that has created today's problems of cost and access to health care.

This report describes the sorry history of the development of American health care policy and the myths surrounding health care economics that have come to be accepted as gospel among reformers. Until health care policy makers disavow these myths and understand the corresponding realities discussed below, American health care policy will continue to founder. This report concludes with recommendations for positive health care policy reform.

The Sorry History of American Health Care Policy[1]

American health care policy has not evolved from careful study and analysis of the health care marketplace. Rather, it has evolved out of a series of poorly informed attempts to pander to certain constituencies and mimic policies of other countries without fully understanding the weaknesses of those policies. The result is a trend that has dissipated the potential advantages of private, competitive markets. Instead of harnessing the consumer's powerful cost-containment and quality control abilities, policy makers have chosen to drastically minimize the role of the consumer. Instead of harnessing the private market, they have implemented a series of heavy-handed and ill-considered governmental interventions in healthcare markets.

Proponents of socialized medicine pressed for such intervention throughout the first part of the 20th century. However, the watershed in U.S. government intervention in medical care began during World War II when the first step was taken to remove consumers from direct responsibility for making their health care spending decisions. This first step was the adoption of tax subsidies for employer-provided health insurance. This resulted in both the implicit subsidization of medical services relative to other goods and services, and reduced direct consumer involvement in the purchase of care. The second, later step was the dramatic expansion of government-provided insurance, through Medicare and Medicaid, and through increased intervention in health insurance and provider markets. The third major step in the socialization of American medicine is being proposed today in the form of *single-payer* insurance. The *single-payer* approach uses government-mandated insurance, direct regulation of provider prices and wages, and controls over the quantity and quality of services in the attempt to contain costs.

The stimulation of private insurance

Prior to World War II, health insurance was a relative rarity, and usually limited only to coverage of catastrophic care or insurance pools covering workers in dangerous industries, such as logging and mining. Such pools were formed in the Northwest logging industry as early as 1870. The health care market was overwhelmingly private, with less than

It is six decades of poorly-crafted public policy that has created today's problems of cost and access to health care.

The adoption of tax-subsidies for health insurance was not an intentional, carefully thought-out policy innovation. In fact, it was an inadvertent side effect of the wage and price controls placed on employers during World War II.

10 percent of health care expenditures paid for by government in the late 1920s versus approximately 50 percent today. Perhaps as much as 90 percent of health care expenditures, therefore, were paid for out-of-pocket in 1929 versus less than 18 percent today.

The adoption of tax-subsidies for health insurance was not an intentional, carefully thought-out policy innovation. In fact, it was an inadvertent side effect of the wage and price controls placed on employers during World War II. Companies began offering health care benefits as a way to attract workers after courts ruled they could do so without violating wage and price controls.

The companies did not report these benefits as employee income, thus they were a tax-subsidized form of income. By the time the Federal tax authorities realized what was going on, the tax-exemption was a political sacred cow. The IRS formally endorsed the tax-exempt treatment of employer-provided insurance in 1954. In effect, a scheme to evade a government regulation became a major feature of American health care policy by default. The proportion of medical payments made through private health insurance rose sharply from less than 3 percent in 1940 to 21 percent in 1960.[2]

Post-war reforms

In the immediate postwar period, some American politicians and labor groups again began advocating direct government involvement in the provision of health care or health insurance. The advocates were enamored of the health care policies that had evolved in central and southern Europe, and Great Britain. Otto von Bismarck had instituted compulsory, national health insurance in Germany as early as 1883. Britain began its National Health Insurance program in 1911, and the National Health Service in 1948. There had been earlier attempts by American reformers to institute national health insurance, but these had been unsuccessful because the public was relatively happy with health care services, and providers were opposed. A number of states considered single-payer plans between1915 and 1920, but none garnered public support. For example, in California in 1918 a voter referendum on state-provided health insurance failed by a 2-to-1 margin.

Mimicking the policies of socialist Europe had greater cache in post-WWII America, despite the fact that the quality of U.S. health care was arguably the best in the world at that time. A Gallup poll in 1945 showed 59 percent of Americans favorably disposed toward national health insurance – much greater support than previously registered. Nevertheless, despite President Truman's strong support, the Wagner-Murray-Dingell national health insurance bill failed to get out of committee in 1947. Later, anti-union and anti-communist popular sentiment killed interest in a national health insurance initiative for the rest of the Truman administration.

Truman's successor, Dwight D. Eisenhower, was opposed to national health insurance. President Eisenhower briefly endorsed Republican Governor Nelson Rockefeller's plan for health insurance that covered the costs of catastrophic care only. Instead, Congress passed the Kerr-Mills Act in 1961. This act provided federal aid to existing state public assistance programs to include a new, medical indigence category as a way of underwriting care to the elderly poor.

Although liberal reformers still wanted national health insurance, popular support for it was weak, and reform continued to be focused on expanding Social Security to incorporate health insurance for the elderly. Public

support for Medicare legislation, as it came to be called, was not particularly strong in the beginning either. It waned with the popularity of the Kennedy administration, but interest was revived and action finally taken under the Johnson administration.

Medicare, the first national health insurance program in the United States was born on July 9, 1965, when Congress approved the Mills Bill (H.R. 6675), and President Johnson signed it into law (Public Law 89-97). Under the new law, Medicare and Medicaid programs became Title XVIII and Title XIX, respectively, of the Social Security Act.

Whereas Medicare is a national health insurance scheme, Medicaid is a state-administered, federally aided medical assistance program for low-income persons. Each state is allowed to set use and dollar limitations on the amount, duration, and scope of Medicaid coverage. Also, thanks to "waiver authority" in the Social Security Act, states have latitude in program design as well, under sections 1915(b) and 1115 of the Social Security Act.

Relative to this general history, Oregon has distinguished itself in a number of ways, including its special waiver version of Medicaid known as The Oregon Health Plan, and in its aggressive regulation of private health insurers. Oregon health insurance law imposes myriad requirements on private health insurers in the state. According to the General Accounting Office, Oregon is considered one of the most restrictive states in terms of its regulation of health insurers. The Oregon Health Plan also has attempted to control costs by rationing the types of services provided and by restricting the reimbursement for prescription drugs dispensed by participating health care providers.

As this brief history illustrates, American policy in general and Oregon policy in particular has increasingly eliminated consumer involvement in health care decisions and finance. Advocates of such policy would argue that this direction has been necessary to ensure that the poor can afford medical care. But with the consumer now responsible for less than 18 percent of health care spending, the important side effect of such policy has been to put the cost and quality of health care at the mercy of government regulatory and insurance policies. It has been so long since economic logic prevailed in this market that health care policy is now driven almost entirely by sound bite policy concepts, most of which involve serious misconceptions about the market for health care.

Health Care Myths

This section of the report is dedicated to exposing eight significant health care myths, and replacing them with their corresponding realities.

Myth 1: The main health policy problem is too little health insurance

If one believed the popular press, all of our problems with health care would be solved if everyone had health insurance coverage. It is popular to bemoan the fact that too many households do not have health insurance, and that the poor cannot afford to pay out of their own pockets for insurance or care because of the high price of care.[3]

This is the fundamental fallacy of modern health care policy. It myopically focuses on ubiquitous, comprehensive health insurance as the solution to the economical provision of good health care. This view ignores the fact that poorly implemented subsidization and overextension of health insurance are, in fact, the likely proximate *cause* of the rising cost of health care.

It is popular to bemoan the fact that too many households do not have health insurance...This is the fundamental fallacy of modern health care policy...This view ignores the fact that poorly implemented subsidization and overextension of health insurance are, in fact, the likely proximate *cause* of the rising cost of health care.

American policy in general and Oregon policy in particular has increasingly eliminated consumer involvement in health care decisions and finance.

The reason is simple. When properly designed and applied, insurance provides an efficient means of *sharing risks.* Risk sharing through insurance is important and economically efficient when there are events that are *rare, costly and difficult to predict*. Earthquakes, sudden death, and house fires are such events, as is treatment for leukemia, a stroke, or the unexpected complications of childbirth. Insuring such events makes good economic sense because, though rare, such risks are financially devastating. Consequently, a rational, risk-averse individual will be willing to pay a little bit, along with others, to be insured against the consequences of such events. This in fact is the theoretical reason for the existence of the insurance market – insurance against rare, but financially catastrophic events.

In contrast, many health events are so common and minor that they are likely to befall most everyone in the population, with the consequence that there is little advantage of risk sharing through insurance. Specifically, the *pro-rata* cost of sharing the burden of common and minor events through private or public insurance will actually be greater than the cost of bearing it individually because of the administrative cost of the insurance. In such cases, there is no *natural* insurance market. This is why routine house painting costs are not insurable, but a house fire is.

However, when insurance premiums are subsidized as a result of tax-exempt treatment of employer-based insurance, demand for insurance of minor, common events will increase. For example, one can be certain that insurance policies to cover painting your house *would exist* if their premiums were tax-deductible.

When insurance coverage is broadened to include common events, there is no significant risk-spreading function performed. What remains, however, is a powerful, distortionary phenomenon economists call *price illusion. Price illusion* occurs when the perceived price of something does not reflect the true cost of that good or service, and creates instead the illusion of low or even zero cost. The effect of *price illusion* is that we as consumers tend to not care about costs of the insured service, and behave accordingly, because someone else will pay for it. It is a basic precept of economics, however, that unless the consumer cares about the price of a service when making an individual spending decision, there will be no price *discipline* in the market. After all, the providers of the service have the opposite incentive – to make prices high!

The tax-advantaged treatment of health insurance generally, and the extension of this treatment to non-catastrophic care insurance in particular, has dramatically increased the importance of the *price illusion* in health care trends. In the medical care realm, about 80 percent of all medical visits[4] involve relatively minor, commonly anticipated medical events. This includes such events as seeking care for common colds, flu, infections, minor injuries, normal pregnancy, etc. Though there is little *risk-sharing* function performed by insuring such events, a potent *price illusion* effect is created which results in the false perception that the service is essentially free, at the margin.[5]

Price illusion stimulates additional spending, with no assurance that the additional spending is cost-beneficial. Indeed, everything else being equal, the lack of consumer discipline in the process virtually guarantees that the additional spending will be excessive and inefficient. As in the case of a group of diners who agree beforehand to split the restaurant

bill evenly, the insurance of common health care services causes us to all spend more than we otherwise would have. The result is overspending, yielding either over-consumption of services or inflation in the price of services or both. The over-consumption effect will dominate in markets where the supply of services is responsive to demand, and inflation will dominate in a market where the supply of services is relatively inflexible. In the market for medical services, there are elements of both these supply conditions, with the result that there is both over-utilization and relative inflation of health care services. By this line of reasoning, it is apparent that the problem with American health care policy is not too *little* insurance, but too *much* insurance and dominance of the *price illusion* effect. American health care policy has virtually extinguished consumer price discipline, with the result that prices of medical services tend to inflate much more rapidly than otherwise.

The inflationary effect of excessive coverage can be documented by examining the pace at which the unit cost of medical services has risen with the broadening of insurance coverage. Even anecdotally, the coincidence of increased coverage and medical services inflation is clear. For example, in 1965 when Medicare was being debated, it was widely lamented that the cost of a day's hospital stay in 1963 was an outrageous $40. After 35 years of expanded Medicare spending, the cost of hospital room and board (when billed separately from nurse and medical services) now exceeds $500 per day in many urban markets. This is twice the cost that can be explained by general inflation alone. Similarly, a simple appendectomy that cost less than $75 in the 1940s cost over $800 by 1989 and costs in excess of $3,000 today. This is nearly four times the cost that can be explained by general inflation alone. According to one analyst of the Medicare program, failure to anticipate the over-utilization and relative inflation caused by Medicare resulted in a six-fold underestimate in projected 1990 costs.[6]

Using the available medical services price index data,[7] the phenomenon can be demonstrated more comprehensively. Under the pressure of expanded government and private insurance coverage over the years, the price of medical services has risen more than twice the rate expected from general inflation factors. This is illustrated vividly in Figure 1.

The effect on utilization has followed a similar path. The *price illusion* created by broad health insurance or government health care provision has caused consumers to increase the consumption of health care services relative to other goods. Health care spending increased from less than four percent of per capita gross domestic product (GDP) to 12 percent in 1996 (and 14 percent today). (See Figure 2.) When the *price illusion* sparks such runaway growth in spending, of course, it is virtually certain that much of the growth is in the form of over-utilization and/or low-productivity expansions in the features of the services provided.

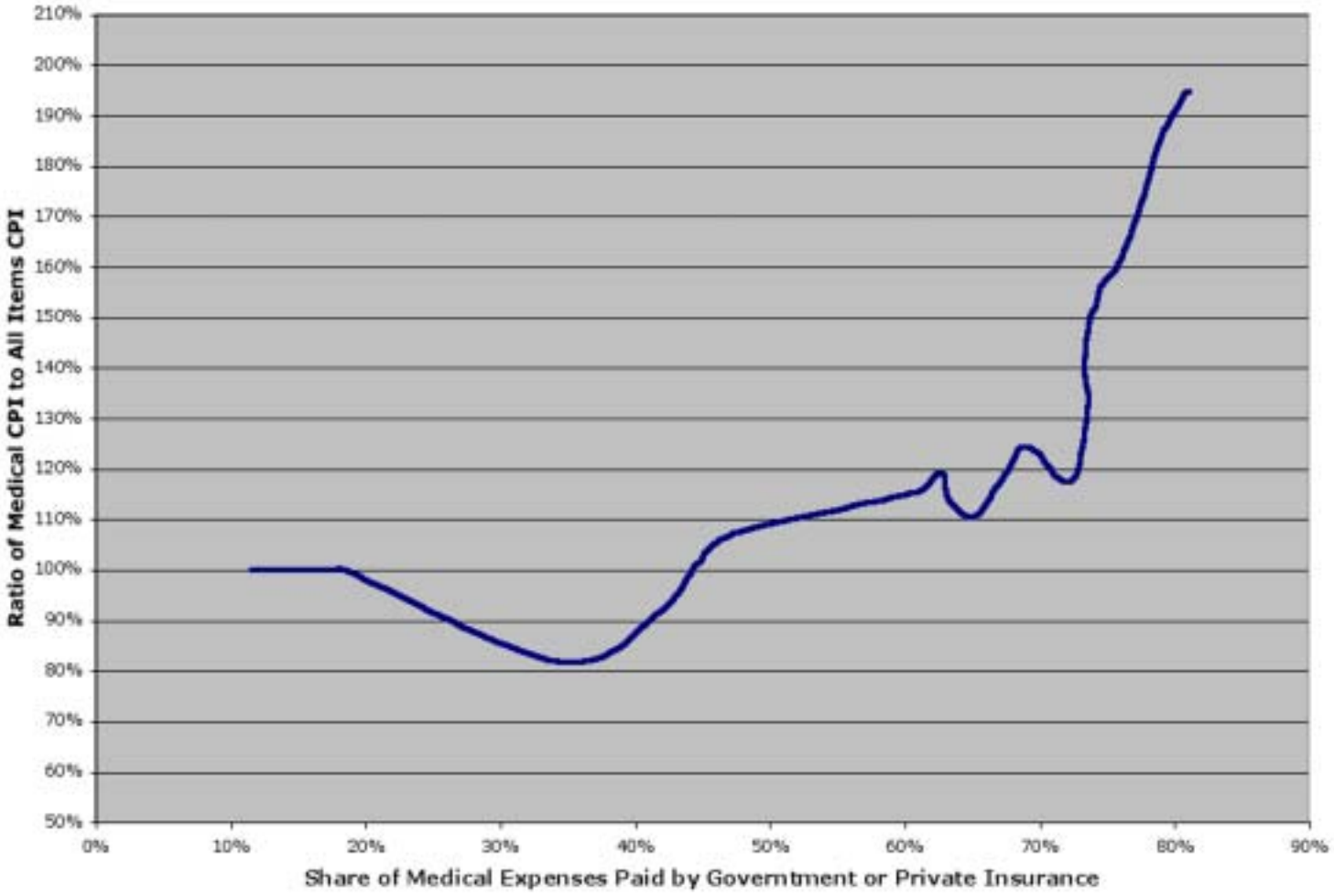
Myth 2: Expanded health insurance coverage benefits the poor

Concern over access to health care by the poor has long driven health care policy in the United States and elsewhere. What advocates of this view fail to understand, however, is that if expanding public or private health care services results in excessive increases in the unit cost of health care, it *creates* accessibility problems for the poor.

If the inflation rate in medical services exceeds the nominal rate of income growth of low-income households, the result can be an *absolute* reduction in the ability of poor households to afford health care services.

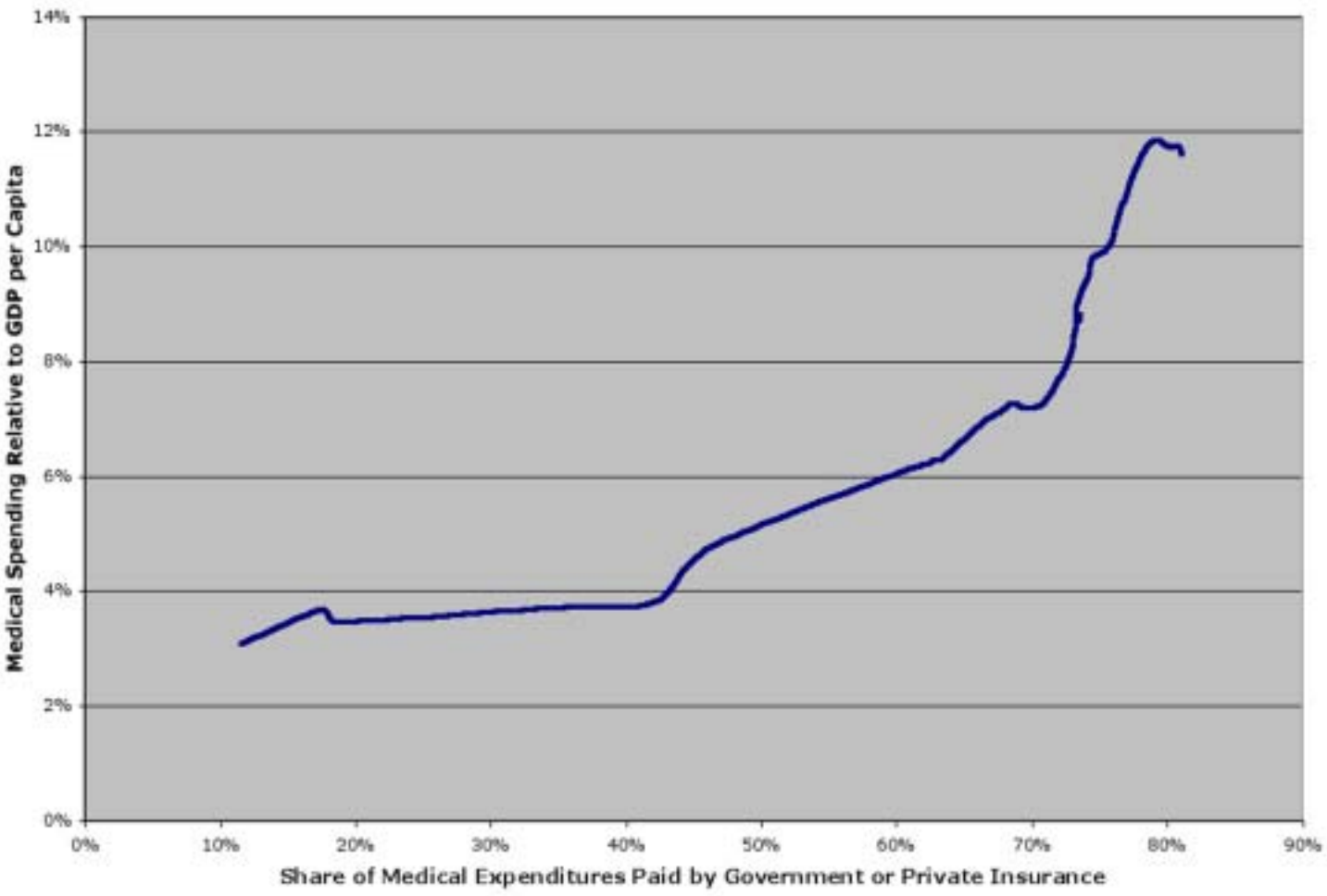
The problem with American health care policy is not too *little* insurance, but too *much* insurance and dominance of the *price illusion* effect. American health care policy has virtually extinguished consumer price discipline, with the result that prices of medical services tend to inflate much more rapidly than otherwise.

Figure 1: Expanded insurance coverage leads to medical inflation in excess of general inflation



Source: Author from U.S. Bureau of Labor Statistics and Health Care Financing Administration data, 1940-1996.

Figure 2: Utilization of health care services rises with increased insurance coverage



Source: Author from U.S. Bureau of Economic Analysis and Health Care Financing Administration data, 1940-1996.

Concern over access to health care by the poor has long driven health care policy in the United States and elsewhere. What advocates of this view fail to understand, however, is that if expanding public or private health care services results in excessive increases in the unit cost of health care, it *creates* accessibility problems for the poor.

Even if household income growth among poor families is greater than medical services inflation it will cause a *relative* reduction in accessibility to health care if the income growth of low-income households is less than that of high-income households.

In the case of the United States in the last 50 years, the effect of medical services inflation has been to significantly degrade the relative, but not absolute, accessibility to health care by the poor. Income growth has been sufficiently high among all income quintiles to permit increases in spending on health care while maintaining spending on non-health services. However, the high rate of medical service inflation caused by overextension of health insurance, coupled with income growth differences, has resulted in a smaller improvement in accessibility to health care by the poorest quintiles. These trends are displayed in Figure 3.

Current health policies have hurt poor consumers in more subtle ways. Before the advent of broad-coverage insurance, the poor often benefited from progressive *price discrimination* practiced by physicians and other providers. Poor households were routinely charged lower fees than well-to-do households. Indeed, prior to the formation of the American Medical Association in 1901, doctors were expected to provide hospital services for the indigent for free.[8] In contrast, under most insurance schemes, a single fee is established for insurance reimbursement purposes, and the provider has little incentive to charge lower fees to the poor.

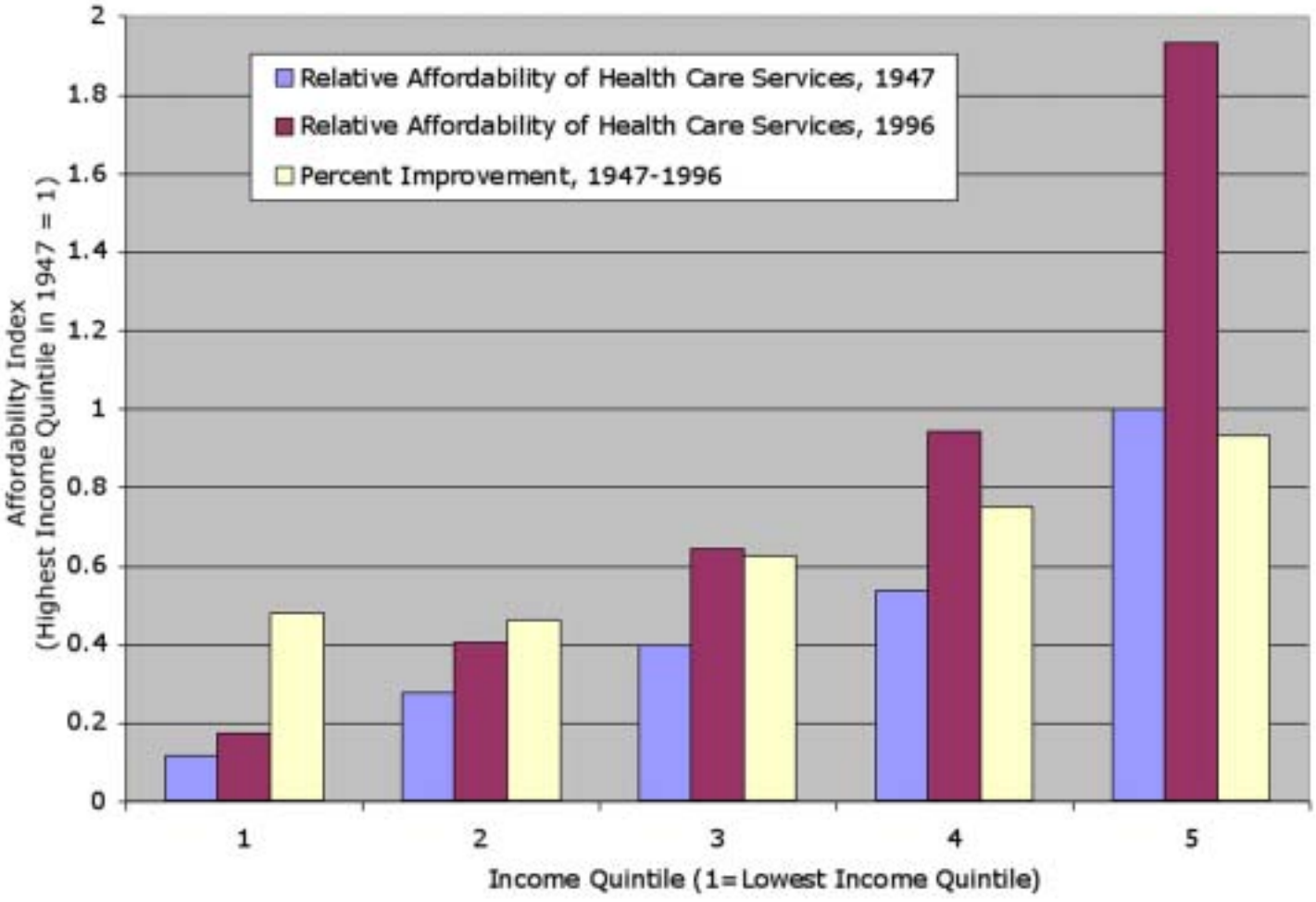
In summary, it is clear that relative access to health care by the poor has not been improved by the policy broadening of private and public health insurance. Incomes have grown rapidly enough to indulge significant increases in health spending and health care. However, much of the health care purchasing power of this income growth has been lost to excessive inflation stimulated by the coverage itself. In addition, in an environment of over stimulated utilization and prices, it is difficult to even develop a yardstick against which to measure the adequacy of health care services for the poor.

Myth 3: Extensive regulation is needed to control problems in the health care market

Many policy makers believe that the ominous inflation and access trends they are observing in the marketplace are an indication of private market failure, and thus the need to regulate the health care market. In fact, regulation of the health care market has been schizophrenic and generally counterproductive. Some regulation has had the effect of expanding non-catastrophic insurance coverage excessively, with the primary effect of *enhancing price illusion* and inflationary pressures. A myriad of other regulations and policies then have been adopted to try to contain the resulting inflationary pressures. In essence, many regulations exist primarily to offset the deleterious effects of other regulations or policies – not inherent market failures.

This is not to say that there is nothing for policy makers to do in the realm of health care. There is an important role for government in helping private insurers avoid attracting only high-risk insureds (the so-called *adverse selection* problem). For example, government mandates that all *individuals* obtain basic, catastrophic care insurance is one way to help insurers in this regard. It focuses policy on those medical events that are appropriate to *risk sharing*, and creates sufficiently large pools to avoid the *adverse selection* risk to the insurer. The Swiss implementation of this policy option will be discussed later in this report.

Figure 3: Trends in affordability of health care services, 1947 to 1996



Source: Author, from U.S. Census, Current Population Survey, Annual Demographic Supplements and Bureau of Labor Statistics data.

Regulations have increased the cost of health insurance by 15 to 25 percent and *increased* the uninsured population. Indeed, the report found that uninsured populations are largest in states with the most regulations.

Policy makers in the United States, however, have been reluctant to mandate that individuals obtain only catastrophic care insurance. Nor have they been content to limit themselves to the narrow goal of containing *adverse selection* in catastrophic care. Instead, they have focused on employer mandates and in many cases have mandated coverage of non-catastrophic events.

The focus on employer, rather than universal, mandates has resulted in a serious distortion of labor markets by health policy. As documented in a recent Federal Reserve System study, making the employer the locus of insurance access distorts job mobility, retirement, and labor-force participation behavior. The effects are dramatic in some cases. For example, the study's authors found that women's job mobility was 30 to 50 percent lower than it should have been because of the so-called "job lock" effect of linking employment and health insurance.[9]

Many regulations are focused on requiring insurers to offer broader coverage than they might otherwise offer, even with the tax subsidy enjoyed by insurance premiums. For example, most states require coverage of such events as normal maternity and childbirth services. Indeed, many states, including Oregon, have made it difficult for catastrophic-care-only coverage to be offered, even when promoted by federal policy experiments.

Mandating expanded coverage simply amplifies the effect of *price illusion* and further fuels medical inflation fires. So, apparently adopting the view that two bad policies equal one good policy, policy makers add other regulations to control the price spiral they facilitated. For example, Medicare, Medicaid and other public insurers try to control health care cost inflation by imposing limits on the prices they will pay for procedures or by limiting the types of procedures that they will pay for. This is a key feature of Oregon's Medicaid plan – The Oregon Health Plan. In still other cases, policy makers try to intervene in the structure of the private market, by permitting the formation of buying cartels to counter the perceived, excessive market power of physicians, pharmaceutical firms, and other providers.

In other cases, public insurers and public hospitals limit the type or price of drugs they will support through, respectively, so-called restricted formularies or reference-based pricing. The latter policy is mainly practiced outside the U.S., but was a recent thrust of Oregon policy. Private insurers, struggling to compete in a general rising tide of costs, will themselves seek ways to contain costs or reduce actuarial risk. The result has been the introduction or growth in the private sector of preferred provider networks, restricted formularies, coverage restrictions, health maintenance organizations and other such efforts. All of these initiatives can be seen as attempts to remedy a weakness that should not exist in the first place: the lack of consumer involvement in the selection of and payment for medical services.

It should come as no surprise that in a marketplace dominated by the inflationary forces of *price illusion*, regulation is ineffective because the consumer still perceives a price distortion, and the market reacts to thwart or nullify the effects of regulations. Regulations to limit the prices paid by public insurers lead to withdrawal of, or *adverse selection* of, private providers willing to offer products and services. Regulations to force insurers to bear unacceptable risks lead to the departure of insurance and health care providers from the market. Managed care and other rationing schemes, whether implemented by private or public insurers, substitute a bureaucrat's

judgment for the judgment of the patient and her doctor. These schemes have alienated consumers and have been a notorious public relations failure, even for good providers.

Anecdotal illustrations of the counterproductive nature of regulation abound. When the state of Washington compelled insurers to offer *guaranteed issue* of individual plans, most insurers simply stopped issuing new individual plans altogether. When the states of Pennsylvania and West Virginia failed to restrain malpractice settlements, most insurers and many doctors simply left those states, leaving them undersupplied with medical services. Conning Research recently published a comprehensive study[10] indicating that, across the 50 states, nearly 1000 separate laws have been passed since 1984 regulating the health insurance market alone, and more than 1800 are on the books. The report concludes that these regulations have increased the cost of health insurance by 15 to 25 percent and *increased* the uninsured population. Indeed, the report found that uninsured populations are largest in states with the most regulations.

Myth 4: We would be better off with single-payer insurance

The notion of national health insurance has been resurrected in U.S. policy debates under the name of *single-payer health insurance.* Ever since Great Britain adopted its National Health Insurance plan in 1911, such plans have been advanced repeatedly, though unsuccessfully, by the likes of Presidents Wilson, Truman, Kennedy and Clinton, generally at the urging of organized labor. Today, these calls are being renewed by some policy makers, including Oregon's Senator Ron Wyden.

Under a *single-payer* plan, there is one insurer and, hence, one arbiter of coverage and compensation policies. Ubiquitous health insurance coverage does nothing to contain the *price illusion* – indeed, it amplifies it because such plans typically have virtually no consumer or employer involvement in cost containment. Thus, *single-payer* plans pose even greater over-utilization risk than today's private system of health insurance. For example, hospital admission rates and lengths of hospital stays historically have been much higher under socialized medical schemes, since patients have no incentive to limit the length of their stays.[11] According to Walter Sulzbach, in his 1947 book *German Experience with Social Insurance*, a primary effect of ubiquitous insurance was to increase the length of time it took a sick worker to recover.[12]

With the *price illusion* so aggressively unleashed, the only way that single-payer plans can contain medical costs is to directly regulate provider compensation and/or utilization. According to a recent analysis by opponents of *single-payer* plans, if the U.S. adopted the management policies of the Canadian national insurance plan there would be 171,000 fewer physicians, seeing on average 921 more patients each per year.[13] This may or may not be bad. But there is no way of knowing whether this is a result that is consistent with efficient or welfare-maximizing care. Under a *single-payer* plan consumers have literally no voice because they do not even have a choice of insurer. In those cases where service provision is also socialized, they have no choice of provider either. This can only adversely affect both the quantity and the quality of care consumers receive.

Countries with *single-payer* plans appear to spend less on health care than does the U.S. However, this observation is superficial and misleading, because all *single-payer* implementations simply have chosen a non-price system for rationing access to care. Namely, queues and other bureaucratic means of dis-

Many regulations exist primarily to offset the deleterious effects of other regulations or policies – not inherent market failures.

The primary effect of the well meaning but ill-conceived Medicare program has not been to *solve* a looming medical catastrophe brought about by an aging society. It has been to *create* a catastrophe, by making medical care more expensive and less accessible for everyone, especially those not eligible for Medicare, i.e., those under 65.

couraging utilization are used instead of prices. The wait for even simple diagnostic procedures in some Canadian provinces, for example, can be in excess of 30 weeks.[14] Queues and poor service quality are an unaccounted-for cost burden of such plans. As any first-year economics student can demonstrate, rationing through queues is actually more costly to the economy than rationing through prices.[15]

In addition, most European countries, where national health insurance systems dominate, keep poor track of private health care expenditures, in contrast to the United States. This is not a trivial data problem, because dissatisfaction with the quality of national health services has stimulated private provision in many countries or the seeking of care from other countries, so the total cost of health care is higher than reported. Nevertheless, even when reported spending on health care is adjusted by per capita GDP and relative prices, socialized systems show *no* cost-control advantage over the American system.[16] In other words, if these other countries had the levels of income enjoyed by Americans, and the relatively lower cost of non-health care goods, they would be consuming the same or higher amount of health care services. These factors are not typically considered by proponents of national health insurance, making their claims of cost savings for *single-payer* plans at best a gross misstatement. Just as importantly, the highest quality *and* lowest cost health systems can be found in countries that rely on the private sector in an intelligent manner, as we will see below.

Myth 5: The aging of America justifies increased government involvement

America is an aging society, and as a society ages the demand for health care service increases. The elderly, like the very young, have about twice the rate of medical visitation as middle-aged individuals. Proponents exploit this fact to increase public sentiment for interventionist health care reforms. Indeed, Medicare legislation was promoted in the early 1960s by creating the impression of a growing catastrophe in hospitalization access by the elderly.

In fact, the catastrophe, such as it was, was at least partly created by government. The percentage of elderly in the population had increased by only about one percent in the 13 years between 1950 and 1963. The cost of a day's hospital stay was only $29 in 1960, and the proportion of elderly with private insurance was growing. Nevertheless, under pressure from supporters of a national health insurance system including President Kennedy and organized labor, Congress passed the Kerr-Mills Act in 1961. Designed to provide federal aid to the elderly, the act created a new medically indigent category for state public assistance programs. In response to the new federal largesse hospital costs jumped immediately from $29 in 1960 to $40 per day in 1963, and private hospitalization insurance use stopped growing.[17] This contrived catastrophe contributed to the passage of Medicare two years later.

In 2000, Medicare had grown to be a $220 billion program, paid for primarily by a 2.9 percent tax on worker's income and general tax revenues.[18] The Medicare spending frenzy has undoubtedly contributed to today's high daily cost of hospitalization, and its failure is creating another, contrived catastrophe – the lack of coverage for prescription drugs.

Ironically, growth in the elderly population *per se* should have contributed very little to health care inflation. A study by Organization for Economic Cooperation and Devel-

opment (OECD) economists in 1995 found that the higher utilization rates and greater numbers of the aged *per se* explained only 3 percent of the growth in health care spending in the U.S. between 1960 and 1990. The other 97 percent was the result of increases in demand (i.e., rising income and the inflationary effects of the *price illusion*). Even for the OECD countries as a whole, most of which have more serious societal aging problems than the U.S., the proportion of health care cost inflation attributed to aging is less than 10 percent.[19]

So, the primary effect of the well meaning but ill-conceived Medicare program has not been to *solve* a looming medical catastrophe brought about by an aging society. It has been to *create* a catastrophe, by making medical care more expensive and less accessible for everyone, especially those not eligible for Medicare, i.e., those under 65. The great irony is that those under 65, as a whole, have significantly less financial capacity than those over 65. According to Census statistics, Americans over 65 have an 80 percent home ownership rate (twice that of adults under 35) and 80 percent of these older homeowners own their homes outright, versus only 24 percent of those under 65. Total assets per capita of the elderly, at $147,000 are twice that of all age groups, and 15 times that of workers under 35, who are also paying through Social Security taxes for the retirement support of rich and poor elderly alike.[20]

An even greater irony, according to a recent analysis, is that the 19 percent share of the personal incomes of the elderly devoted to health care is no lower today than it was when Medicare was passed. And after 35 years of so-called cost containment efforts by the Medicare bureaucracy, unit costs of Medicare services continue to grow much faster than general inflation and, by some measures, faster than non-Medicare services.[21]

Clearly, an aging society is insufficient reason, *per se*, to further enlarge government's role in the direct provision of health care or health care insurance. To date, government's role on this pretext has been mischievous and inflationary. A better role for government would be to assist the indigent, of whatever age, in obtaining basic, catastrophic care insurance as needed.

Myth 6: Prescription drug prices are the cause of health care cost inflation

Pharmaceutical firms are the new whipping boys in the debate over health care policy reform. For example, two Harvard professors who are editors of the *New England Journal of Medicine* recently railed, "It's time to take a hard look at the pharmaceutical industry and hold it accountable."[22] In Senate testimony on June 6, 2002, Senator Ted Kennedy asserted that it was "irresponsible to accept the excessive [drug] cost increases that patients face today" and recommended limiting drug companies' patent rights and their right to market directly to consumers.

Germany, sagging under the weight of its out-of-control national health insurance costs, issued a 39-page regulation to impose price ceilings on 112 major drugs, by package size and dose.[23]

In 2001 Oregon legislators faced out-of-control growth in the cost of the State's Medicaid program, The Oregon Health Plan (OHP). Their proposed solution was a reference-based pricing scheme similar to that used in British Columbia. Such a plan would limit compensation under the OHP to the cost of the "approved" drugs. This proposal was put forth as HB 3300 in the 2000 Oregon legislative session.

Countries with *single-payer* plans appear to spend less on health care than does the U.S. However, this observation is superficial and misleading, because all *single-payer* implementations simply have chosen a non-price system for rationing access to care.

An $18 *increase* in spending on new drugs was associated with a $72 *decrease* in other components of medical spending...Political posturing aside, the reality is that prescription drugs have been the salvation of health care cost inflation in the past, and are likely to offer the most significant opportunity for health care productivity improvement in the future.

Closer inspection of the facts, however, reveals that growth in drug spending actually has been a blessing in disguise. It is true that drug prices and drug utilization have been rising rapidly. Between 1990 and 2000, total spending on prescription drugs has grown at a rate of about 10 percent per year versus 6 percent for physicians' services and health services generally.[24]

But, in fact, higher drug spending is actually helping to bring *down* the cost of health care. How can this be, if drug prices and utilization are on the rise? The answer is that drugs are an economical and productive substitute for more-expensive, alternative modes of medical care.

Health care historically has been very labor intensive, requiring the efforts of doctors, nurses, orderlies and other support personnel. In the modern regulated context, it also requires fleets of lawyers, regulatory compliance staff, insurance claims administrators, and other non-medical staff. In many instances drugs are highly economical substitutes for the hands-on efforts of medical staff labor and hospital services, and are increasingly used in lieu of such services. More than 60 percent of the growth in drug spending is due to such increased utilization, and less than 40 percent is due to drug price inflation *per se*, according to a recent, federally sponsored study. [25]

Although prescription drug price inflation has been greater than the non-medical consumer price index, it has been less than the inflation rate for the services of medical professionals (doctors, dentists, nurses, etc.), and less still than that of hospital services.[26] Thus, if drugs are good substitutes for non-drug spending, *substituting drug spending for other spending will lower the cost of medical care.* Thus, it is not the price of the drug that matters, but its total effect on the cost of care.

For example, in the United Kingdom health officials recently determined that a new, antipsychotic drug (Seroquel®) was more cost effective than the older drugs even though the new, specialized drug costs almost 20 times more per person per year than the traditional drugs.[27] -The reason is that the old drugs' effectiveness was limited, and affected individuals remained a costly burden on doctors and hospitals. More comprehensive studies have confirmed that drugs in general are a cost-effective substitute for other medical care spending. Some of these studies are on specific drugs and drug classes.[28] However, Columbia University professor Frank Lichtenberg recently measured the productivity of this substitution phenomenon comprehensively using the 1996 Medical Expenditure Panel Survey data.[29] He found that an $18 *increase* in spending on new drugs was associated with a $72 *decrease* in other components of medical spending.[30]

The attacks on the pharmaceutical industry and drug prices divert public attention from the role that public policy has played in inflating health care costs and diminishing accessibility. Political posturing aside, the reality is that prescription drugs have been the salvation of health care cost inflation in the past, and are likely to offer the most significant opportunity for health care productivity improvement in the future. If the evidence from the European experience with drug market intervention is any guide, this opportunity to reduce total health care costs will be dissipated by the heavy-hand of government intervention.[31]

Myth 7: Drug company profits are too high

Politicians are fond of pointing to drug company profits as an indication of the excessive-

ness of drug prices. They argue that drug companies should be spending less on marketing, such as direct advertising to consumers, and more on R&D. They also assert that drug companies use loopholes in the 1984 Hatch-Waxman Act to monopolistically suppress generic competition.

The attack on industry profits is not a new issue. The industry's profits were investigated by the Kefauver Commission in the 1950s. What is new is that the attacks are increasingly successful, as activist senators like Ted Kennedy, John McCain, and Charles Schumer have advanced anti-industry legislation. For example, the McCain-Schumer Bill passed the Senate on a 78-12 vote in July 2002. The bill revises the Hatch-Waxman Act to further limit the brand-name drug manufacturers' ability to fend off generic competition. The bill also attempts to limit the ability of drug companies to charge different prices in different markets by allowing "re-importation" of drugs from countries where the drugs are sold at lower prices. Attacking on a different front, the State of Vermont in June of 2002 became the first state to pass a law to discourage drug companies' marketing of their products to health care providers.[32]

What is disappointing about these political trends is the fact that there is virtually no evidence to suggest that drug companies are too profitable or spend too little on R&D. In fact, a recent study of the industry was performed by one of America's most renowned professors of antitrust economics, F. M. Scherer.[33] He concluded that "profit rates of return on pharmaceutical industry R&D investments tend to exceed risk-adjusted capital costs by only modest amounts" and that the profit-seeking behavior of the industry is, overall, "virtuous". Contrary to the industry's critics, Scherer also found a very high positive correlation of 92 percent between profit levels and R&D levels.

Since there are little, if any, excess profits from drug development, any government policies that reduce industry profits will reduce R&D spending and drug innovation with virtual certainty.

Myth 8: Drug company's spend too much on marketing

Criticism of the industry's efforts to market aggressively is also misguided. More than perhaps any other industry, pharmaceutical manufacturing is characterized by high fixed costs of research, development and testing, and relatively low marginal costs of actually manufacturing the medication.

This unusual cost structure means that if a drug company were subject to immediate competition from generic manufacturers who can avoid the fixed costs of development , it would never be able to recoup its development costs. Thus, for a pharmaceutical company to profitably develop new drugs, it must have some mechanisms to recoup the tremendous fixed costs of developing a successful new drug.

There are two, interrelated mechanisms that companies use to recoup these costs. The first mechanism is protection from generic competition. Patent laws provide, but limit the duration of such protection. In addition, Federal Drug Administration (FDA) regulatory procedures significantly raise the fixed cost elements of testing and waiting to gain approval for new drugs. Indeed, government intervention in the testing and approval of drugs has, over time, contributed significantly to the cost of introducing new drugs and has significantly reduced the rate of introduction of beneficial new drugs. For example, according to studies of the key interventions passed in 1962, the effect of

If drugs are good substitutes for non-drug spending, *substituting drug spending for other spending will lower the cost of medical care.*

Reforms like *single-payer* insurance will only deepen the distortions that current policy has already created...The logical reform is to only provide insurance against catastrophic medical costs, and to find a way for consumers to conduct the other 80 to 85 percent of their transactions with the medical profession on a cash, or quasi-cash basis.

FDA policies has been to reduce the rate of new drug introductions by nearly two-thirds.[34]

The second mechanism to recoup fixed development costs involves increasing market penetration of the company's drugs so as to spread these high fixed costs over more consumer sales. They do so both by aggressive marketing and by sacrificing profits-per-unit to obtain higher sales in markets where the ability to pay is limited. For example, selling a new drug in a poor African country for $20 while the same drug sells for $100 in America may actually be beneficial to all consumers, as long as marginal costs are being covered or exceeded in both markets. Contrary to the misguided logic of their critics, if the drug companies were unable to market their drugs in this manner, they would have to charge *higher* average prices to American consumers in order to recoup fixed development costs from a smaller sales base.

The same logic justifies selling drugs for lower prices in relatively affluent Canada than in the U.S. If government policy in Canada keeps prices below what drug companies need to recoup high fixed costs, it still may benefit American consumers for the companies to make those Canadian sales. American consumers need to realize that if drug companies were forced to sell their products anywhere at prices that reduce their ability to profitably recoup their development costs, the companies will be less likely to develop new drugs in the future, as demonstrated by Scherer's research. This marketing behavior is not unique to drug companies. Any company with high fixed costs and low marginal costs for its products (such as a software company or an airline) must, and does behave the same way. Indeed, marketing expenses are a *larger* fraction of profits for most software companies than for most drug companies. And airlines routinely charge different passengers different prices for the same flight, in order to make the service available to as many users as possible. These strategies are to the consumer's benefit, because they lower unit costs and, in the long run, encourage innovation.

What seems to irk the medical profession most about drug company sales behavior is direct marketing to the consumer. Restrictions on such marketing efforts were lifted in the 1980s after years of direct marketing bans. For any other product, of course, giving the consumer more information would be considered a good thing. In the topsy-turvy world of modern health care, where consumer involvement in decision-making and payment has been virtually eliminated, having knowledgeable consumers is an inconvenience. As one Oregon legislator, who happens to be a physician, remarked to the author in 2001, "I had to spend five minutes of my time talking a patient out of using a medication she had seen on TV. That is a waste of my time." This statement reveals the passive role that consumers are expected to assume in modern American health services markets.

The Solution is Simple: Bring Back the Consumer

As this brief review of American health care policy makes clear, the main features in American health care policy have been fourfold:

1. Virtual elimination of consumer responsibility in health care decision making and finance. The market is dominated by the effects of *price illusion, where prices increase because the consumer doesn't pay and therefore has little reason to care.* Clumsy regulatory

attempts to control the resulting cost spiral have replaced consumer discipline with cumbersome and bureaucratic rationing and cartel-like managed care schemes.

2. Over reliance, as the result of a tax distortion, on insurance for mundane medical services. Insurance should be focused primarily on catastrophic care. Otherwise, the *price illusion* will dominate health care spending decisions and price trends.

3. Excessive and unjustified government involvement in the provision of health insurance. To maintain price discipline in the marketplace, government involvement in health insurance and the provision of care should be strictly limited.

4. Over-regulation of the prices, services and practices of providers, insurers, and pharmaceutical manufacturers. Many of these regulations are unnecessary even under current policy, and even more would be unnecessary with proper health care reform.

Reforms like *single-payer* insurance will only deepen the distortions that current policy has already created. What is needed instead are the following two policy changes:

1. The role of the consumer in the market for medical services needs to be reasserted. This can be done by making the consumer responsible once again for selecting and paying for health care services directly. Only insurance of catastrophic, not mundane, medical events should be encouraged by tax policy.

2. Financial assistance for the purchase of medical services should be provided to poor individuals in a way that does not risk the counterproductive effects of the *price illusion* resulting from over-insurance or subsidized care.

Therefore, the logical reform is to only provide insurance against catastrophic medical costs, and to find a way for consumers to conduct the other 80 to 85 percent[35] of their transactions with the medical profession on a cash, or quasi-cash basis. This lowers administrative overhead[36] throughout the delivery system, and enhances competition. It also focuses insurance on only those truly catastrophic, uncommon and unpredictable health events that deserve to be insured.

The Singapore approach: medical savings accounts

The device preferred by many economists that can accomplish the above goals is the medical savings account (MSA).[37] It has been used in Singapore beginning in 1984. (It is implemented today through Singapore's *Medisave Medishield* and *Medifund* policies.[38]) MSAs have been available in a limited, experimental form in the United States, as well. The MSA gives the consumer a special, tax-protected account from which they may pay their out-of- pocket health care costs, or allow the account to grow for retirement, or (in Singapore) for a first-home purchase. This approach provides a way of making sure that adequate funds are available for the consumer to make necessary payments. But it also gives the consumer an incentive to husband the funds carefully, since funds not spent on medical care can be used in retirement. The poor can be easily accommodated in such a scheme by subsidizing, as necessary, the initial funding of their MSA balances.

Selling a new drug in a poor African country for $20 while the same drug sells for $100 in America may actually be beneficial to all consumers, as long as marginal costs are being covered or exceeded in both markets. Contrary to the misguided logic of their critics, if the drug companies were unable to market their drugs in this manner, they would have to charge *higher* average prices to American consumers in order to recoup fixed development costs from a smaller sales base.

American health care policy is in a completely predictable cost, service and access death spiral.

Where such remedies have been applied there is a dramatic reduction in the unit costs of care. In Singapore the share of gross domestic product that goes to health care is a mere 25 percent of the U.S. level, without significant differences in outcomes.[39] Indeed, the American system is a target of official scorn in Singapore. Its official national policy is to "…avoid unrestricted and open ended medical insurance as practiced in the U.S., which leads to the provision of unnecessary medical services and escalating premiums."[40] Hong Kong has elected to adopt the same approach to containing its health care costs.

The Swiss approach: mandatory basic insurance

There is another mechanism, which is something of a hybrid of U.S. policy before 1965 and the Singapore approach. Switzerland mandates that every individual obtain limited basic insurance. The insurance is not provided through employers or the federal or cantonal governments. However, the cost of basic insurance is assisted through public subsidy, as needed, for indigent workers and the elderly. Although consumers are permitted to obtain supplementary insurance, over-insurance is reduced by requiring that such insurance be obtained at the consumers' expense, without special tax treatment. In the absence of American-style regulatory intervention, co-payments are common and relatively high, further containing the tendency toward over utilization and cost inflation.

The results of the Swiss approach are interesting, and make it obvious that good quality health care can be provided by the private sector with limited state involvement. In Switzerland, the provision of insurance and the provision of medical services is almost entirely in the hands of the private sector, with the state only playing a role in defining the features of the basic insurance care product and providing subsidies to the indigent. In contrast to the U.S., this policy has successfully preserved small private and community fee-for-service providers, and care is available without any artificial queuing. The Swiss spend approximately 30 percent less of their GDP on health care than does the U.S.[41]

Conclusion

From an economist's viewpoint, American health care policy is in a completely predictable cost, service and access death spiral. American policy fails to recognize that the person who generally best understands the value of and need for medical care is the individual or the family who is seeking it. Rationing and managed care solutions to cost control are doomed to failure because they inherently stand in the way of consumer sovereignty.

The reassertion of consumer sovereignty in health care is the only feasible means of containing health care costs while assuring that the consumers obtain the health care services they need. Interestingly, after 110 years, even the granddaddy of socialized health care systems, the German system, has recognized that limiting over-insurance, and reasserting private sector involvement, is the solution to runaway health care costs.

Here is what the executive director of the Institute of Social Medicine and Health Economics at University of Magdeburg in Germany had to say earlier this year:

> The German health care system is stuck. Experts and politicians of any couleur agree about the urgency of reforms in health care. From the point of view of … health economists, the system should be freed of extensive regulation imposed by the state and

> corporatistic bodies. [Reforms are needed] on the demand side of health care. In Germany, health care services are zero-priced, leading to excess demand. … The present financing system is basically a tax on labour. It aggravates the existing distortions in production and labour supply decisions due to social security contributions and income taxes. … [In contrast] financing health care through [private]premiums does not distort individual decisions, since premiums reflect expected services of the insurer.[42]

Americans should not have to experience 100 years of growing government involvement in health care before we recognize what Germans increasingly understand. We can replace the eight health care myths with economic realities, and return consumer sovereignty back into our health care marketplace. Then all Americans, rich and poor, will have better opportunities to receive the health care they need at prices they can afford.

In Singapore the share of gross domestic product that goes to health care is a mere 25 percent of the U.S. level, without significant differences in outcomes.

Notes

[1] This section has benefited from Peter Corning's excellent political history of Medicare, but the interpretations and facts offered in this report should not be attributed to that author. See, Peter Corning, *History of Medicare*, Social Security Administration, 1969.

[2] The actual proportion of medical expenditures covered by private insurance prior to the 1940s is unknown. The author has estimated this figure from other sources and US Census data. See, for example, Odin W. Anderson, "Private Expenditures for Drugs and Other Components of Medical Care: A Brief Review from the 1920s to the Present," Odin W. Anderson, December 1959.

[3] Leighton Ku, "The Number of Americans without Health Insurance Rose in 2001 and Appears to be Continuing to Rise in 2002," Center for Budget and Policy Priorities, September 30, 2002.

[4] The highest proportion of medical *costs* is associated with catastrophic care.

[5] In the extreme case, some medical events are not only predictable, but intentionally precipitated, such as normal childbirth, or well-known consequences of other, voluntary behaviors. Insuring these events is particularly problematic, because the insured person can buy insurance knowing beforehand that the event will happen with near certainty or high probability.

[6] Sue Blevins, *Medicare's Midlife Crisis* (CATO Institute; 2001), p. 54.

[7] The Bureau of Labor Statistics publishes medical price index data. There is debate whether this index adequately (or excessively) accounts for changes in the quality of medical services.

[8] See, for example, the health care policy timeline at http://www.pbs.org/healthcarecrisis/history.htm.

[9] Buckmueller and Valetta, "Health Insurance and the US Labor Market," The Federal Reserve Bank of San Francisco's *Economic Letter*, April 17, 1998

[10] Conning Research & Consulting, "State Regulation of Health Insurance: The Unseen Crisis," (Hartford, CT; 2002).

[11] Howard Oxley and Maitland MacFarlan, "Health Care Reform, Controlling Spending and Increasing Efficiency", Working Paper 149 (OECD Economics Department: Paris, 1994), Table 14.

[12] Cited in Richard M. Eberling, "National Health Insurance and the Welfare State: Part II," February 1994.

[13] Pete du Pont, "Single-Payer Health Care By Any Other Name Is Still A Monopoly", Opinion Editorial: National Center for Policy Analysis, Tuesday, April 2, 2002

[14] "Ontarians wait up to 30 weeks for key tests," *National Post*, Tuesday, October 01, 2002

[15] Rationing to achieve any given level of economic activity is always more costly to the economy than using prices. The reason is that rationing through price assures that those for whom the rationed service has very high value will still be able to obtain the service. Rationing through queues or other means inefficiently discourages consumption both by low-value users and high-value users. In addition, pricing generates a transfer of cash, which can be spent by those receiving it in

productive ways elsewhere in the economy. Rationing through queues, on the other hand, causes individuals to lose forever wasted time, lowers productivity while ill, and imposes other negative effects. There is no way to capture and "recycle" these impediments to consumption as can be done through pricing.

[16] Oxley and MacFarlan, op cit p 82.

[17] Peter Corning, *History of Medicare*, Social Security Administration, 1969, Chapter 4.

[18] In fact, the effective rate is about 25 percent higher because employees are taxed on their Medicare contributions.

[19] Oxley and MacFarlan, op cit Table 5.

[20] Summarized from the testimony of Maya MacGuineas before the U.S. House Ways and Means Subcommittee on Health, March 27, 2001, 2:00 p.m.

[21] For an excellent summary of Medicare's disappointing performance, see Blevins, *op cit*.

[22] Marcia Angell and Arnold S. Relman, "Prescription for Profit," *The Washington Post*, June 20, 2001, Page A27.

[23] Ned Stafford, "Germany issues drug price limits as part of new law", June 12, 2002 (Frankfurt; Reuters Health)

[24] Calculated by the author from data from National Health Expenditures, 1999. National Health Statistics Group, US Office of the Actuary.

[25] M. Merlis, "Explaining the Growth in Prescription Drug Spending: A Review of Recent Studies," U.S. Department of Health and Human Services, August 2000.

[26] Between 1990 and 2000 prices of prescription drugs and supplies inflated by 4.5 percent, versus inflation in non-medical goods and services of 2.6 percent. However, professional medical services grew by 4.9 percent, and hospital services by 5.9 percent. (Source: author, from U.S. Bureau of Labor Statistics data).

[27] "UK Health Body Backs Newer Schizophrenia Drugs," Reuters Health, June 6, 2002. According to the article, Seroquel® costs £1,220 per person per year versus only £70 for the traditional drugs.

[28] See, for example, Chantal Bourgault, MSc; Eleanor Elstein, MD; Jacques Le Lorierm MD, PhD; Samy Suissa, PhD "Reference-based pricing of prescription drugs: exploring the equivalence of angiotensin-converting-enzyme inhibitors," CMAJ 1999;161:255-60; Andrea K. Biddle, M.P.H., Ph.D., Ya-Chen Tina Shih, Ph.D., and W. Jacqueline Kwong, Pharm.D., "Cost-Benefit Analysis of Sumatriptan Tablets versus Usual Therapy for Treatment of Migraine," Pharmacotherapy 20(11):1356-1364, 2000.

[29] Medical Expenditure Panel Survey (MEPS)www.meps.ahrq.gov/data_pub/hc_toc.htm

[30] Frank R. Lichtenberg, "Are The Benefits Of Newer Drugs Worth Their Cost? Evidence From The 1996 MEPS", Health Affairs, Sept/Oct 2001.

[31] "Market interventions do not have the expected or desired long-term economic impact. Changes in policy can have a short-run impact on pharmaceutical spending, but over the longer run there is no difference between spending levels or spending growth in countries with many market interventions and in countries with few or none." From,

"Ensuring Cost-Effective Access to Innovative Pharmaceuticals: Do Market Interventions Work?", Boston Consulting Group, April 1999, pp. 24.-26

[32] "Vermont Governor to Sign New Rule on Drug Marketing", Reuters Health, June 13, 2002. With implementation of this rule, Vermont requires pharmaceutical manufacturers to disclose payments and gifts made to healthcare providers when promoting their drugs.

[33] F. M. Scherer, "The Link Between Gross Profitability and Pharmaceutical R&D Spending," Health Affairs, Sept/Oct 2001.

[34] Sam Peltzman, "An Evaluation of Consumer Protection Legislation: The 1962 Drug Amendments. Journal of Political Economy, 1973, Vol. 81, no. 5: 1049–91.

[35] In 1995, for example, approximately 80 percent of all insured individuals filed claims of $2,000 or less per year, and only 1.8 percent of insured individuals filed claims exceeding $25,000 in one year. These rare, but very large claims are the appropriate realm for insurance coverage. Source: American Academy of Actuaries, "MSAs: Costs and Design Issues," May 1995.

[36] Administrative costs are in excess of 15 percent of insurance costs, not including the administrative burden borne by the patient and the provider. Source: American Academy of Actuaries, "MSAs: Costs and Design Issues," May 1995.

[37] Briefly stated, medical savings accounts involve placing funds in special accounts that use to buy health services directly, other than insurance. Consumers are allowed to use funds not spent on health care as part of their retirement income. This gives consumers the incentive to use the funds wisely, and to buy health care services in a cost-conscious way. This introduces consumer sovereignty and the forces of competition into the health care marketplace.

[38] See, http://app.internet.gov.sg/scripts/moh/newmoh/asp/you/you01.asp for a description of these three components.

[39] According to the World Health Statistics Table, published in 2000 by the World Health Organization, Singapore equals or outperforms the U.S. is virtually every measure of health care system performance: child mortality rates, maternal mortality rates, life expectancy, immunization rates, child malnutrition, and youth death rates. It achieves this performance while spending 4 percent of GDP on health care vs. 14 percent in the United States. Singapore's per capita income is approximately 70 percent of the U.S. level.

[40] In 2000 and 2001, this statement was at a now-dead link in the Ministry website at http://www.gov.sg/moh/mohiss/afhlter.html. The MSA-like features of the Singapore health policy are now articulated at http://app.internet.gov.sg/scripts/moh/newmoh/asp/you/you01.asp, and this criticism is no longer explicitly stated, though it is clearly implied by the Ministry's health care philosophy statement at the same site.

[41] Prof. Dr. Stefan Felder, "Reform of Germany's Health Care Market," Institute of Social Medicine and Health Economics, University of Magdeburg, Germany, Berlin, May 8, 2002.

[42] Felder, op cit.

CASCADE POLICY INSTITUTE

813 SW Alder, Suite 450
Portland, Oregon 97205
(503) 242-0900

info@cascadepolicy.org
www.cascadepolicy.org
fax (503) 242-3822