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Five Myths about Rising Healthcare Premiums

Getting the facts right

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Overview: Healthcare Premiums Rising Again

The cost of healthcare insurance coverage in the US has moved, yet again, firmly into high inflation mode. Last year saw another double digit increase in healthcare insurance premiums, the third straight

More workers strike over healthcare benefits

Grocery and transit workers walk out in Los Angeles, disrupting lives. Strikes also loom from Ohio to Virginia.

By [Daniel B. Wood](#) | Staff writer of *The Christian Science Monitor*

SHERMAN OAKS, CALIF. — Chai Laplander is having a challenging day.

After quadrupling her usual commute time from the distant suburb of Santa Clarita - thanks to a strike by bus mechanics - the nonunion grocery worker had to cross a line of angry picketers outside the local Ralph's grocery where unions are staging the region's first supermarket strike in 25 years.

As she scans paper towels and produce in a checkout lane, she offers a resigned

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year of such rapid growth. Premiums have increased on average by 50% since 1999, and the average annual cost for insuring a family of four is now over \$9,000.¹ The last time the nation experienced this was in the late 1980's, and the problems then were instrumental in ushering in the HMO revolution of the early nineties that seemed to contain premiums for a number of years.

The issue of rising health insurance premiums is creating turmoil in many areas of our economy. Many firms, particularly in

heavily unionized industries, have simply provided healthcare insurance as part of the pay package. But in a weak economy firms cannot easily absorb these costs increases. As such they have been playing a significant role in many of the labor disputes being seen around the US, including the 4-month grocery strike here in Southern California that occurred as a result of the efforts by management to pass on a portion of these increased costs to employees. It has also been playing a role in labor disputes in Pennsylvania, Minnesota, Washington and Virginia among other places.

Rising healthcare premium

GM health care bill tops \$60 billion

Cost adds \$1,400 per vehicle, hurts competitiveness

By Ed Garsten / *The Detroit News*

DETROIT — [General Motors Corp.](#) is expected to report this week that its future obligation for employee and retiree health care topped \$60 billion last year, and new Medicare legislation will do little to reduce the expenses.

The crushing health care burden will be detailed in GM's year-end financial report with the U.S. Securities and Exchange Commission, the company said.

The \$60 billion figure represents a sharp increase in the automaker's projected obligations from 2002. In recent months, GM officials have said soaring health care spending has become the leading factor undermining the automaker's competitiveness.

GM's health care costs now account for \$1,400 per vehicle, a severe handicap as the world's biggest automaker battles to recover market share in an environment of falling vehicle prices.

<http://www.detnews.com/2004/autosinsider/0403/11/a01-88813.htm>

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¹ Kaiser Family Foundation (www.kff.org)

costs have played a large role in the Worker's Comp crisis here in California that is hurting many businesses, particular those that are small and medium sized. These rising fixed costs may also be playing a substantial role in discouraging businesses from hiring new workers. When employee costs rise, firms have the incentive to substitute capital for labor, outsource jobs or simply make their existing workers work more in order to make up for the additional expenses. This is likely to be one reason for the jobless recovery. A number of businesses who have offered healthcare packages as part of their retirement programs, such as the big three automakers, are struggling to meet these unexpected—and therefore unfunded—expenses and are suffering competitively as a result. Many State governments are finding it

Calif. doctors still back insurance plan

SACRAMENTO, Calif., March 15 (UPI) -- A controversial plan to require most California companies to provide health benefits survived a significant challenge at a physicians' conference.

The California Medical Association rejected a proposal to drop its support for the new law, known as SB 2, which is up for repeal on the November ballot.

<http://www.washingtontimes.com/upi-breaking/20040315-120927-8357r.htm>

difficult to fund infrastructure and educational programs because of the rising costs of maintaining their existing public health programs not to mention providing healthcare coverage to public employees.

The result of this surge in prices has been, as might be expected, a variety of finger-pointing and new legislative actions being taken at both the State and Federal levels. This includes California's controversial plan SB-2 which will require firms of above a certain size to offer healthcare plans to employees or pay into a special government fund that will be used to subsidize health coverage for the working uninsured. New calls

for universal coverage are also being discussed, not to mention price controls particularly on pharmaceutical products and also on insurance premiums as per the currently proposed SB-26 here in California. It has also been a driving force behind the hotly debated expansion of benefits under both Medicare and Medicaid programs.

To be able to evaluate these proposals, we must first understand why premiums have been rising so fast. To this end I set out to talk about five common myths about healthcare coverage costs and explain why they are wrong. The first myth is that premiums are rising because of profiteering on the part of insurance companies and HMO's. The second myth is that the rising numbers of uninsured people are driving up premiums. The third myth is that pharmaceutical products are a primary driver of rising premiums costs. The fourth myth is that the US has a primarily private healthcare system when compared to other industrialized nations, and the fifth myth is that rising healthcare premiums are a function of rising prices, not increasing real consumption of services. Each of these will be examined in turn.

Myth #1: Rising healthcare costs are a function of profiteering by insurance companies

One common call has been that healthcare premiums in the US have been climbing because of profiteering and excessive administrative costs on the part of the private insurance companies. In reality the reason that healthcare premiums are rising so fast is quite straightforward: it is due to the fact that healthcare spending in the US is rising rapidly. Growth in healthcare expenditures paced nominal GDP for much of the nineties, indicative of the cost-controlling ability of the HMO's plans that came into play during the period. However the last four years have been marked a sharp divergence in the two trends. Even as overall economic activity slowed, spending on health has accelerated to a pace not seen in over a decade.

Single-payer health plan gains support from nation's physicians

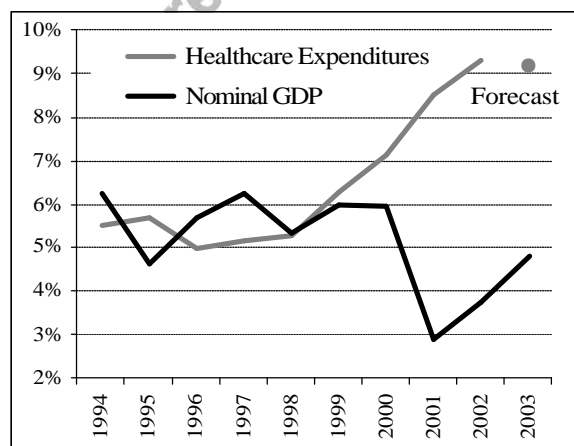
In a resounding show of strength for universal health care, almost 8,000 U.S. doctors endorsed a plan recently that would provide health coverage for all Americans, regardless of employment status or ability to pay.

Published in the Aug. 13 issue of the Journal of the American Medical Association, the Physicians' Proposal for National Health Insurance calls for a national U.S. health plan that would cover all necessary medical care, including long-term care, mental health care, dental services and prescription drugs, thereby improving the health of all Americans.

"In the current economic climate, we can no longer afford to waste the vast resources we do on the administrative costs, executive salaries and profiteering of the private insurance system," said Marcia Angell, MD, senior lecturer in the Department of Social Medicine at Harvard Medical School and an author of the JAMA article. "It's time to put those resources into real health care - for everyone."

<http://www.apha.org/journal/nation/singlepayercover1003.htm>

Annuals Growth Rates in Healthcare Expenditures and GDP
Nominal Values

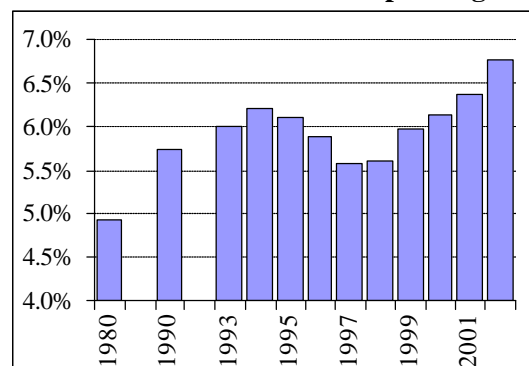


Source: Centers for Medicare & Medicaid Services

The total bill for healthcare in 2002 came to a whopping \$1.55 trillion, approximately 14% of GDP. To put this in perspective total spending on the national defense in 2002 was \$450 billion. Total US exports summed up to \$1 trillion. Total spending on business and residential investment was 1.58 trillion. The current forecast from the Centers for Medicare and Medicare Services is that expenditures will rise by nearly another 8% in 2003 once the final numbers are released. This has been heralded as good news since it implies that spending is no longer accelerating. However this still represents an increase in spending of an additional \$130 billion, and a rate almost double total GDP growth.

How much of this is administrative costs? Not that much, in reality. Total administrative costs in 2002 (for both public and private programs) were only 6.7% of total expenditures. This is up by about 1 percentage point since 1997, but hardly enough to explain the rapid increase in overall spending. And when we consider the patterns of stock returns over the past 15 years, insurance companies have not performed significantly better than the market—indicative of an industry making average returns, not excessive returns. Indeed healthcare companies, medical equipment manufacturers and the producers of pharmaceutical products have all seen significantly better returns over the past decade and a half.

Administration costs as % of spending



Source: Centers for Medicare & Medicaid Services

Relative Stock Performance by Industry
Calculated relative to market average 88-03

Healthcare	2.5%
Medical Equipment	6.8%
Pharmaceuticals	5.8%
Insurance	1.0%

Source: Kenneth French website

Unfortunately much of the debate over the appropriate policies to pursue to handle rising healthcare premiums largely misses the point. Most of the discussion simply revolves around who will end up paying for all these new expenditures, as opposed to worrying about why this acceleration in healthcare spending is occurring that is driving up premiums. It is analogous to a group of people who regularly dine in a particular restaurant together. After a normal visit the bill arrives and it turns out to be much larger than usual. Instead of bringing up the discrepancy to the owner to find out why the price for the meal was larger than anticipated and talking about how to avoid these unusually large bills in the future, our diners are simply debating over who is going to pay the extra amount.

The reality is that regulating insurance companies, having the government pay for healthcare, forcing businesses to provide health coverage for employees, or many of these other plans simply alter how we pay for our healthcare, not how much is paid which is the real problem. When the government expands Medicare and Medicaid programs it doesn't control costs, it only passes the expenses on to tax paying workers and businesses. When businesses pay for healthcare coverage, higher premiums imply reduced wages and longer hours for employees. When more healthcare services are consumed, even if covered by insurance, we end up paying for this expansion of services through higher insurance premiums. As economists like to pontificate- there is no free lunch, or in this case no free healthcare.

Total spending on healthcare grew from \$1.22 to \$1.55 trillion between 1999 and 2002 according to the statistics collected by the Centers for Medicare and Medicaid Services, an increase of \$330 billion. So what is driving up healthcare expenditures? Let's take a look at this question by considering some of the common myths regarding rising expenditures, first about who is paying for it and second what it is being spent on.

Myth #2: Rising healthcare costs are a function of rising number of uninsured

One commonly put forward theory of rising expenditures is that the uninsured have much to do with rising costs. There are two main theories for this. One is that the uninsured make healthcare more expensive because those without insurance tend to pay more for services than those with insurance, due in turn because insurance companies have the leverage to bargain with providers to lower costs. The other theory is the so-called 'cost-shifting' argument, that uninsured raise the price of services by forcing hospitals to raise prices for insured individuals in order to cover the costs of serving the uninsured and presumably non-paying portion of the population.

A good theory?

The Role Of The Uninsured/Underinsured In The Rising Cost Of Health Care

About 5 million individuals face the challenge of low income, ongoing health problems and no health insurance. When you have a limited income, medical care is often delayed. The delay in medical care increases the risk of complications and the advancement of health problems. Therefore, when the individual finally seeks medical care, the costs are normally greater.

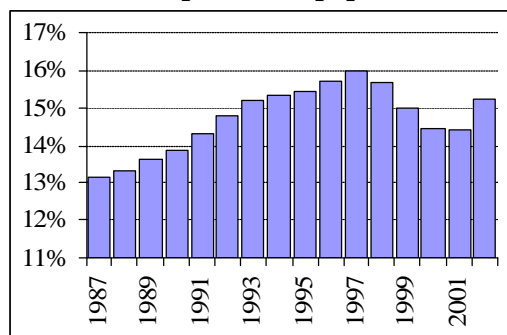
The uninsured individual often cannot afford to pay for medical care. The underinsured can afford health insurance, but the health insurance does not cover all charges and the underinsured cannot afford any out-of-pocket expenses. As a result, cost shifting occurs. This means that the cost of the care is shifted or transferred to other patients with health

<http://www.fepbluc.org/newsletters/newsltr-may03/newsltrfeature-may03.html>

uninsured seems to be more likely to be the *result* of rising premiums, (not to mention a weakening economy and rising unemployment) rather than the cause of rising premiums.

It should also be kept in mind that well over half of the uninsured tend to be adults between the ages of 18 and 34—in short, those least likely to need extensive coverage. Many of the uninsured are clearly voluntarily so; for those on a tight budget, justifying the high cost of insurance when the probability of need is very low simply doesn't make economic sense. Indeed it has been suggested that

Uninsured as percent of population



Uninsured by Age; 2002

Under 18 years	11.6%
18 to 24 years	29.6%
25 to 34 years	24.9%
35 to 44 years	17.7%
45 to 64 years	13.5%
65 years and over	0.8%

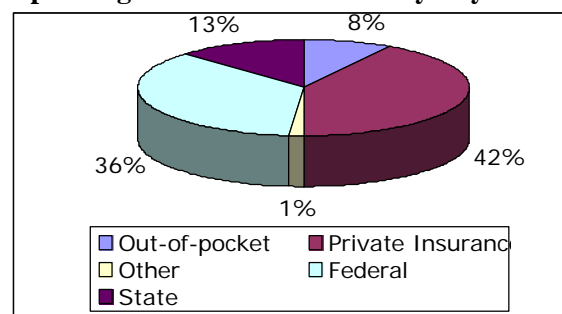
Source: Census

the increase in public coverage for children has played a role in rising rates of the uninsured adults. Many young adults with children get healthcare coverage for their children. With the state stepping in to provide this coverage, it is natural that some adults may choose to drop their personal coverage. Of course in a system that relies upon cross-subsidization (with the healthy supporting the sick) as much as the current health system in the US, when these folks leaving the market tend to drive up insurance premiums for those that are left, because average expenditures rise. But this doesn't drive up expenditures or costs—it only shifts costs towards those that consume the products.

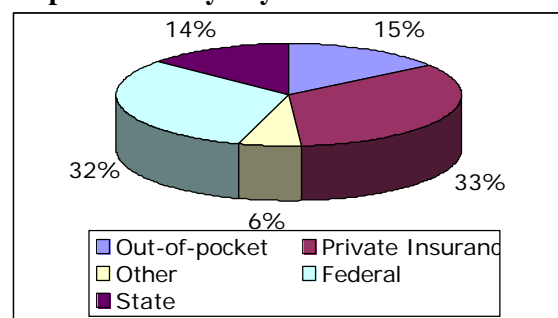
Another bit of evidence comes from the patterns of changes in how healthcare services are being paid for. Of the \$330 billion increase in spending between 1999 and 2002, private insurance companies paid 42%. This is considerably larger than the 33% of total healthcare expenditures that private insurance covered in 1999. This, of course, explains why premiums have been rising more rapidly than total expenditures—insurance has been paying for a larger than normal amount of recent increases. In contrast out-of-pocket spending has experienced the smallest increase of the four major payer type—accounting for only 8% of the \$330 billion increase in spending over the last three years. This conflicts with the theory that the uninsured are largely the reason for rising healthcare costs because of their lack of buying power in the market, since this portion of the spending has grown the slowest.

The shift in spending from the uninsured to the insured does tend to support the cost-shifting

Spending Increases 1999-2002 by Payer



Expenditures by Payer 1999



Source: Centers for Medicare & Medicaid Services

argument—premiums are likely to be driven up some by hospitals covering non-payers. But the cost-shifting argument is fundamentally flawed in that if the uninsured did in fact pay the costs of the services they have consumed there would simply be an offsetting increase in out-of-pocket expenditures to any decline in private insurance spending, and it would do nothing to help the overarching issue which is that total expenditures are rising rapidly. Indeed if the pundits are right about market power and pricing, then such cost-shifting should actually reduce healthcare expenditures since the uninsured have become functionally insured.

Myth #3: Drug prices are a primary reason for rising healthcare expenditures

Pharmaceutical products have been taking a lot of the blame for rising healthcare costs in the US, and have been in the center of the controversies surrounding the importation of drugs from other countries and Medicare reform. The focus on pharmaceutical products is due in part because spending on drugs has been growing at twice the pace of total healthcare spending—55% in the past three years compared to 27% for overall healthcare costs.

Drug Companies Must Slow Out-of-Control Price Increases, AARP Tells CEOs

Passage of the landmark Medicare Prescription Drug law last year was a victory for older Americans. It will benefit millions of people in Medicare and their families, especially those with low incomes and high drug costs. But our work is not over.

The new law gives us an opportunity to now focus on an issue that our members and millions of Americans tell us is paramount – the high cost of prescription drugs.

In a [letter](http://www.aarp.org/prescriptiondrugs/informed/Articles/a2004-03-08-rxceowhy.html) which is being sent today to the CEOs of the major pharmaceutical companies today, AARP is urging the industry to

Of course it also has to do with some horrible PR that the industry has, in many cases understandably, received. Pharmaceutical companies commonly use aggressive price discrimination schemes—both at home with generics and name-brand products, not to mention internationally with much lower prices in other nations including our two neighbors Canada and Mexico. It should be noted that the

vast majority of large firms in the US use similar pricing schemes for their products; it is hardly unique to this industry. Add to this the billions the industry is spending on promoting new products, the very high profit margins and it is easy to see why it has become a favorite target for those looking to place blame.

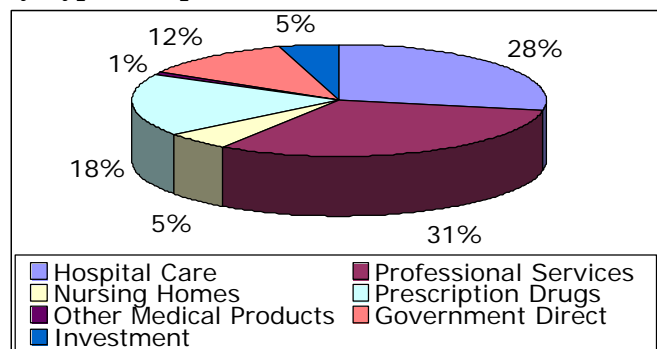
Expenditures by Type, 1999 and 2002 (\$Billions)

	1999	2002	% Ch
National Health Expenditures	\$1,223	\$1,553	27.0%
Hospital Care	\$394	\$487	23.6%
Professional Services	\$398	\$502	26.1%
Nursing Home and Home Health	\$122	\$139	14.3%
Prescription Drugs	\$104	\$162	55.6%
Other Medical Products	\$48	\$51	6.1%
Government Direct	\$117	\$156	33.8%
Investment	\$41	\$57	38.6%

Source: Centers for Medicare & Medicaid Services

Yet what is being missed here is that direct spending on pharmaceutical products still represents only about 10% of total spending in healthcare. Hence while spending on drugs is the fastest growing portion of spending among the various categories, it turns out that spending on drug contributed less than *one fifth* to overall \$330 billion increase in healthcare spending seen between 1999 and 2002. In contrast increases in spending on hospital care contributed 28% to this bill and professional services (primarily non-hospital medical services) contributed another 31%.

Contributions to Healthcare Expenditure Increases by Type of Expenditure: 1999-2002



Source: Centers for Medicare & Medicaid Services

Additionally, pharmaceuticals may have a positive side to them that is often ignored. One reason for rising costs has been the biotech revolution that has allowed the industry to create a plethora of new products that treat a variety of ailments better than previous goods, or where no previous good existed. While expenditures on drugs have been rising rapidly, inflation in this sector of the industry is only slightly above healthcare in total. Much of the expenditure increases is due to quality gains—not just price increases.

It is understood by many researchers that pharmaceutical products play a very important role in cost containment in these other large portions of the national healthcare bill by providing a topical treatment that can reduce the need for more hands on (and more expensive) therapy from professionals. Spending on computers has risen more rapidly than spending on other types of industrial equipment. This is because information technology is now the dominant technology in production. No one would argue that this calls for price controls on computers. Similarly chemical solutions to health problems are also becoming a dominant technology in medicine. A researcher Frank Lichtenberg calculated that for every additional dollar people spend on prescriptions, they save an average of \$3.65 in hospital bills.² Hence rising drug prices may actually be helping contain the crisis to some extent.

Why have pharmaceuticals being singled out if they represent such a small portion of spending?

² "Are the Benefits of Newer Drugs Worth Their Cost? Evidence from the 1996 MEPS," Health Affairs 20(5), September/October 2001, 241-51.

One reason is that it remains one of the few places that consumers still pick up most of their own tab, especially seniors. As the industry substitutes away from therapies that tend to be covered by insurance with these chemical solutions that are not, consumers feel more of the pinch. And in a nation that seems to believe that we should get what we pay for in all sectors except healthcare, it is not surprising that political opposition would start to arise.

This is not to say that the pharmaceutical industry doesn't solve some fundamental economic issues that need to be addressed and it is certainly contributing to the healthcare spending crisis in a real way. Patent protections are currently very generous and as a result the industry has one of the highest profit rates—what most economists would view as evidence of economic rents being collected. New biotech products may never be taken off patent protection under current rules. Furthermore the industry has every incentive to extend this legal monopoly power as much as possible, and it does. Yet trying to regulate prices in this industry would be the wrong way of dealing with this issue—instead the patent laws that provide pricing power would be a more logical place to start since that is the true root of this problem.

Myth #4: The US is the only industrialized nation to have a primarily private health system

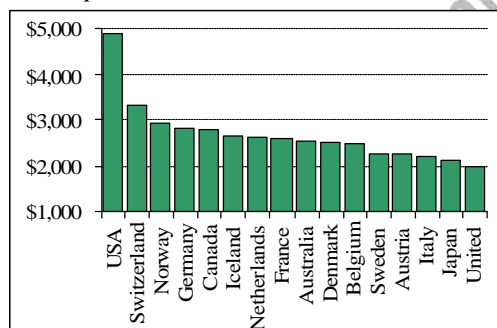
As in the early nineties in the wake of the last healthcare cost crisis, discussion of a substantial overhaul of the healthcare system in the United States has begun. Often other industrialized nations are often looked to as potential models for the US. Europe, Japan and Canada all have single-payer government systems, with largely universal coverage for the population. Indeed, a quick glance would seem to support this position; the US has less public funding as a percent of total healthcare spending, 44% as opposed to an average of 75% for a selection of other industrialized nations.

On the other hand, this doesn't necessarily imply that the US does not already have a substantial public healthcare system. Consider that in 2001 the US spent \$2,200 per person on publicly funded healthcare services, 3rd highest in the selection of industrialized nations chosen, and considerably above the average of \$1,900 spent per capita on public healthcare for the 17 nations represented in this sample, all of which are considered to have a public system. Canada spends only \$2,000 per person on publicly supplied health services. This gap becomes considerably more substantial when we consider that public healthcare only covers 15% of the population here in the US, while public programs in most industrialized nations cover a wider group, although it should be acknowledged that the segment of the population covered in the US, seniors and the poor, tend to be the most expensive populations to serve.

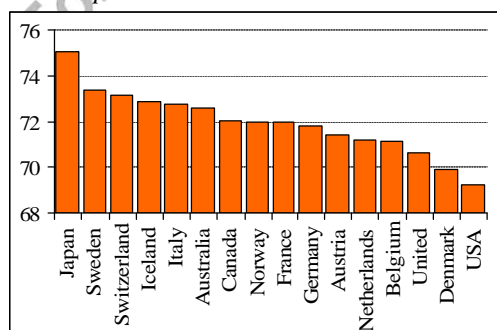
What this result truly reflects is the degree to which total spending on healthcare here in the United States is so out of line when compared to other industrialized nations. When we add up public and private spending in the US on healthcare, the total comes to nearly \$5,000 per person per year. Number two among all nations is Switzerland which spent a mere \$3,300 per person in 2001, a full third less. Canada spent in total \$2,800 per person. To make an earlier point about drug prices that much clearer, if the US required all drug companies to provide their products for free to consumers in the US, this would only cut our bill by \$500 per person per year leaving us still substantially above any other developed nation.

But do we get our money's worth? The US

Total Healthcare Spending
Per Capita in International Dollars

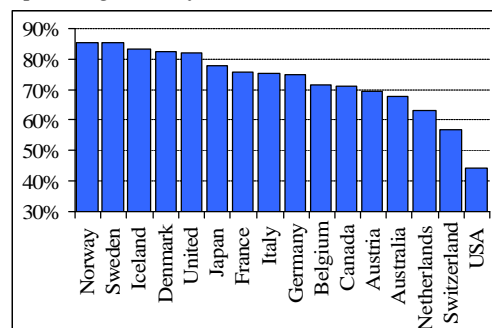


Healthy Life Expectancy
Total Population at Birth

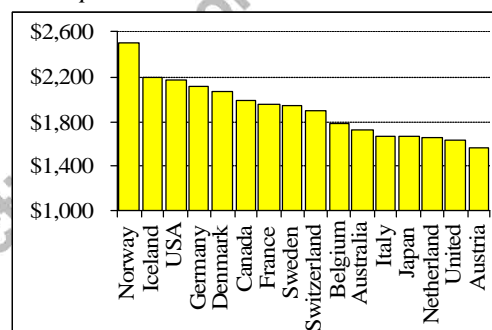


Source: World Health Organization

Government Funding of Healthcare
Spending as % of Total



Public Healthcare Spending
Per Capita in International Dollars



Source: World Health Organization

spends more than other nations on many goods and services on a per person basis, and this isn't necessarily a bad thing. If we choose to spend more on healthcare because the US is richer or simply has a taste for health services, then there really isn't any news here. We can go on home assured that things are fine. Unfortunately the reality is that looking at a number of basic statistics the US does not look to be healthier than these other nations despite our large expenditures. The healthy life expectancy at birth in the US is currently the lowest of all these developed countries. Our infant mortality rate is also higher than most of these other nations. Part of these number may be explained by differences in behavior. Violence and incidences of HIV are higher in the US. Certainly the obesity rate in the US is higher than in these other nations as well. Yet the average

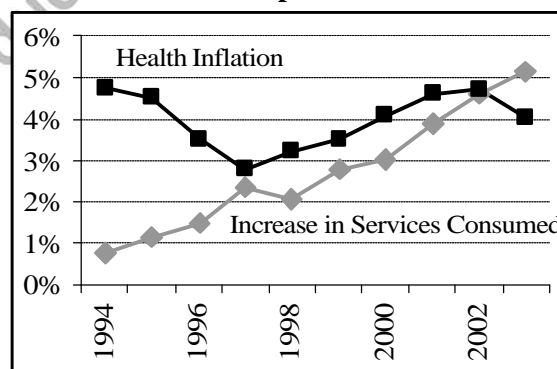
person in the US smokes an average amount relative to our European neighbors, and the average person in the US drinks less than a European. Most importantly the proportion of the population above 60 years of age is considerably lower in the US when compared to other industrialized nations because of the high levels of immigration over the past two decades, and the single strongest indicator of personal healthcare expenditures is not income or weight, it is age. It is clear that outcomes do not provide an explanation for this spending gap.

Myth #5: Rising expenditures are primarily a function of the rising price of services

Another common idea is that rising healthcare expenditures and the fact that spending in the US is so much higher than in other industrialized nations is largely a function of inflation in the industry—that consumers of healthcare are getting the same level of service they always have and simply paying more than before. It is true that healthcare cost inflation explains some of the increase in expenditures, but only about half since 1999. Real increases in consumption have been driving the other half of the overall increase.

Furthermore it is well understood that trying to measure inflation in healthcare services is remarkably difficult since it relies on measuring changes in quality as well as in quantity. How, for example, does one measure the true increase in price when a new more effective and expensive drug replaces an older version? In a sector of the economy where market forces dominate the answer can be found by trying to measure the ‘price’ that the market puts on certain quality characteristics. In healthcare market forces play little role because of insurance. True inflation might be lower or higher—but likely to be lower. Add to this the basic economic understand that increased demand pushes price up and it is clear that rising expenditures in the US is at least as much of a *consumption* problem as a *pricing* problem if not more so.

Inflation and Consumption



Source: Bureau Labor Statistics, Centers for Medicare and Medicaid

So why does the US have a healthcare over-consumption problem? It all stems from a fundamental economic failure known as an externality problem. Healthcare naturally relies heavily on risk pools because of the level of uncertainty regarding individual need. In this situation those individuals

unfortunate enough to become ill or suffer some accident will have their medical care paid for out of a general fund pool. Additionally the public system in many nations relies on the young to support the health needs of those with the most predictable of all ailments—aging. There is, however, a downside to such a system of group cost coverage; individual consumers do not directly take into account the full marginal cost of the services they are consuming, instead costs are spread over the entire pool of insured individuals. Because individuals do not internalize these costs, it considered to be an externality.

When people do not internalize the full costs of their consumption they will demand more services than if they did, just as people tend to eat more and more expensive food when they are splitting the bill with others than when they simply pay for themselves. This concept is known as the tragedy-of-the-commons in economics, due to the age-old problem of the over grazing of public lands by private individuals. How much of a gap is there? The average household in the US currently spends 5% of its disposable income on healthcare.

Compare this to the 15% spent on healthcare as a nation. Of this amount half goes toward insurance payments. In short the average American pays for one sixth of what we consume. The balance is made up for by business and public spending on coverage.

Household Spending on Healthcare

Age	Income after taxes	Total Healthcare	% Income	Health Insurance	% Income
Total	\$46,934	\$2,350	5.0%	1168	2.5%
Under 25	\$20,206	\$640	3.2%	285	1.4%
25-34	\$46,875	\$1,417	3.0%	762	1.6%
35-44	\$58,457	\$1,980	3.4%	1023	1.8%
45-54	\$60,923	\$2,550	4.2%	1180	1.9%
55-64	\$50,306	\$3,007	6.0%	1356	2.7%
65 and older	\$28,674	\$3,586	12.5%	1886	6.6%

Source: Bureau of Labor Statistics

Similarly, the doctors who prescribe these services do not directly internalize the cost. Indeed the ethics of healthcare insists that everything that can be done for a patient should be done with little regard to the cost of procedures. Again, the incentive is to over-prescribe procedures, products and services that have small health benefits and large price tags. It should be understood that neither the doctors nor the patients are doing anything ethically wrong, only that they are responding predictably to the incentives they are being provided with. Regardless, the net result is an increase in the total quantity of services being consumed and a corresponding increase in the prices for these services. This problem has been intensified as the market has begun to cover even regular, non-variable expenditures such as regular checkups and routine treatments.

So how do other nations manage to control this problem in their public systems? They do so

through the use of quotas. In nations with nationalized systems a certain number of resources are supplied to the healthcare sector, and those who cannot be accommodated in the system simply aren't. The US currently has between 2 and 3 times as many MRI machines per million people as Canada does. We have twice the rate of open-heart surgery. These statistics likely reflect the flaws in both systems; we probably have too many machines and too much surgery and they likely have too few and too little.

One major difference between the Canadian system and the US system, however, is that there is still a private sector to go to in Canada if you are denied treatment through public means. In short, it is easier to make up for rationing than it is for over consumption when a private sector exists. Of course this leads to another conundrum: when the private sector becomes involved, a pricing mechanism is used to ration care. This implies that the better off receive better care than others. While we tolerate the rich driving better cars and living in larger houses, the idea of the wealthy receiving significantly better healthcare offends many people. For better or for worse, healthcare is not a standard consumable good in the minds of many people.

It is clear that for the US to control expenditures it needs to control healthcare consumption—that benefits need to be aligned with costs. It is simply not economically efficient for everything that can be done to be done, as is commonly the practice in healthcare. Instead a cost-benefit analysis needs to be applied to the consumption of healthcare. When we as a society consider the benefit of treating an ailment with a certain procedure, we need to consider the loss of real resources involved in the process. When another nurse is hired, and when another MRI machine is installed, and when another prescription is filled out, this takes real resources from other places inside the economy. Our education system suffers, as does our infrastructure and our various other aspects of our economy that competes for these scarce resources with healthcare.

This is no simple task. A pure price mechanism, as used in most markets in a capitalist economy, has the political and risk-pool problems already mentioned. The last bout of healthcare-itis in the US was cured in part by the HMO revolution. The HMO model was simple—it was healthcare insurance that controlled consumption through the use of bureaucratic gatekeepers and pre-defined rules instead of pricing mechanisms. In other words this is how other government healthcare systems work to contain costs. Unfortunately this system has many flaws. It appears capricious to those in the system, and leaves many dissatisfied customers in its wake. The populist appeal of going after the HMO was too large of a temptation for many a politician and the net result was to break the system through legislative action and public campaign. Now costs are rising dramatically again and blame seems to be going to all the wrong

places. Now a case is going before the Supreme Court on whether individuals can sue an HMO for services not provided. This will, of course, take the last remaining ability for the HMO's in this nation to control consumption and increase the already growing problem.

Our too Medicare and Medicaid suffer from the same flaws. While other nations put in systems that had cost control as one of the basic goals of the system, the US system simply provides coverage with almost no controls. One result of this is that the system, as it currently stands, will simply not be solvent as America continues to age. A recent study shows that the system will go bankrupt by 2019 as a result of the current pace of cost increases.

Medicare May Go Broke by 2019

By Warren Vieth and Vicki Kemper
Times Staff Writers

1:11 PM PST, March 23, 2004

WASHINGTON — Escalating costs and expanded benefits are pushing Medicare toward insolvency sooner than expected, the government said today, increasing pressure on the White House and Congress to rein in health care spending.

The trust fund that covers hospital benefits for 41 million elderly Americans will run out of money in 2019, seven years earlier than projected a year ago, according to the annual report of Social Security and Medicare trustees.

http://www.latimes.com/news/nationworld/nation/la-032304medicare_lat,1,2210240,print.story?coll=la-home-headlines

Supreme Court to hear Texans' suits against HMOs

3/19/2004 7:30 PM

By: Associated Press

WASHINGTON -- The U.S. Supreme Court will hear arguments Tuesday in two Texas cases involving HMO refusals to pay for longer hospital stays.

Here's a look:

Ruby Calad sued Cigna Healthcare of Texas after she had to check out of a Houston hospital the day after a hysterectomy because Cigna wouldn't pay for a longer stay. A few days later, the Sugar Land woman was rushed to the emergency room with complications.

Juan Davila of Ponder sued Aetna Health after it refused to pay for a more expensive pain pill recommended by his doctor. The post-polio

<http://www.news8austin.com/content/headlines/>

The first step is clearly education.

Economics is called the dismal science because it constantly reminds us that we live in a world of limited resources. While it would be nice to be able to provide the best healthcare to all people at all times, the basic limitation on our society to produce wealth prevents this. It must be understood that what *can* be done isn't necessarily what *should* be done. Unfortunately in matters of

life and death these choices, however appropriate, can be agonizing. Consider that according to best numbers available, nearly one quarter of healthcare spending is spent on people in the US in the last year of their life. It is clear that many procedures run on individuals as last efforts are largely wasted. But having to make the call not to have a procedure done, even though it has some small chance of helping, is a decision that most of us would never want to have to make.