Statement

M. Todd Williamson, M.D.

President, Medical Association of Georgia

Committee on Energy & Commerce

Re: Health Care Reform Discussion Draft

June 25, 2009

Good morning, Mr. Chairman and members of the committee. My name is Todd Williamson, and I want to thank you for the opportunity to speak to you today on reforming the nation's health care system and preserving the private practice of medicine. This is an issue that is vitally important to the medical profession, our patients, and our country.

I'm a board certified neurologist. I treat patients on a daily basis in Lawrenceville, Georgia, which is northeast of Atlanta. I also have the privilege of serving as the president of the Medical Association of Georgia, which is the leading voice for physicians in the state. And I have had the great privilege of speaking on behalf of a coalition of twenty state and specialty medical societies[1] that represents more than 100,000 physicians. This coalition was responsible for elevating a physician's right to privately contact with his or her patients to the top of the American Medical Association's advocacy agenda. We believe it is the single most important action we can take to reform the medical care system in this country. I'll come back to that in just a few moments, but I want to begin my testimony by addressing some of the assumptions that serve as the basis for the discussion draft.

---

[1] Medical Association of the State of Alabama, Arkansas Medical Society, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, Guam Medical Society, Kansas Medical Society, Louisiana State Medical Society, Medical Society of New Jersey, North Carolina Medical Society, Oklahoma State Medical Association, South Carolina Medical Association, Tennessee Medical Association, Texas Medical Association, Medical Society of Virginia, West Virginia State Medical Association, The Triological Society, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Neurology.

Peter Orzag, the Director of the Office of Management and Budget, recently said that, "Nearly 30 percent of Medicare's cost could be saved without negatively affecting health outcomes if spending in high and medium-cost areas could be reduced to the level in low-cost areas." We disagree with the stance that we can simultaneously reduce health care expenditures and improve the quality of care by eliminating the so-called "unexplained" geographic disparities. The claim that there is no relationship between how much we spend on health care services and the quality of our care is flawed and emanate from a single source: the Dartmouth Atlas and Health Policy Group. The Dartmouth group is known for its "30 Percent Solution" theory.

The Dartmouth group uses Medicare data on spending and quality to postulate that there is no difference between high and low spending areas in terms of quality of care or outcome. This is the same data and thought process used by Atul Gawande in his New Yorker article, *The Cost Conundrum.* They are convinced that there are too many doctors ordering too many tests. A member of the Dartmouth group went so far as to say in *The Atlantic* magazine that, "if we sent 30 percent of the doctors in this country to Africa, we might raise the level of health on both continents."

The comments are offensive but, more importantly, the theory is simply wrong.

I would urge members of this committee to look at the work of Dr. Richard Cooper, who is a Professor of Medicine at the University of Pennsylvania's Wharton School. Dr. Cooper has raised some serious questions about the methodology and assumptions that the Dartmouth group used to come to its conclusions.

First, he points out that Dartmouth's conclusions are based solely on Medicare data, which represents just a fraction of the health care expenditures. That means Dartmouth's data is incomplete. In an article that was published in the journal *Health Affairs*, (attached) Dr. Cooper demonstrated the weakness in the conclusion. The article abstract read that, "Based on broad measures of health system quality and performance, states with more total health spending per capita have better quality care. Quality results from

the total funds available and not from Medicare or any other single set of payer data. Moreover, Medicare payments are disproportionately high in states that have a large social burden (due to poverty and associated factors) and low overall health care spending." [emphasis added]

Second, Dr. Cooper says a cursory examination of the data reveals that the communities that were studied differed in significant ways. He says that factors like poverty – and associated factors like education, inadequate family and social support – are far stronger data points for predicting health care spending and outcomes than Medicare data.

The vast majority of physicians have dedicated their lives to treating disease and easing pain and suffering. Yes, "greedy doctors" do exist – but they are few. They don't reflect my profession, and they certainly don't exist in the kinds of numbers that would be needed to validate the Dartmouth theory.

If the 30 percent theory is wrong, then not only will we fall short of realizing the large savings attributed to the discussion draft, but the new regulatory and administrative burdens that are embedded in the discussion draft will raise costs and divert funds away from what is really needed – patient care.

The suggestion that health care expenditures in the U.S. are greater than other countries is also false and misleading. Different countries account for medical spending – including out-of-pocket payments and the costs of long term care – in different ways. Some countries do not count the cost of nursing home care as a health care expenditure. And countries can most certainly drive down costs if they deny or ration patient care based on age. The percentage of patients receiving kidney dialysis in the U.S. is nine times higher than for age-matched patients in Great Britain. This age disparity is caused by rationing in the U.K. which does not cover dialysis for people over age 65. Additionally, the cost associated with researching and developing the world's medications, medical devices and procedures distort our costs in the U.S. And, because we are more affluent, Americans are more likely to pursue elective treatments for significant, but non-life threatening

conditions like migraine headaches. It's imperative that we compare apples to apples when we examine health care expenditures on a global basis.

Another faulty assumption that we believe has been used as the basis for the discussion draft is the notion that health care outcomes are worse in the U.S. than in other countries. The physicians I know believe that the medical care we provide in the United States is the best in the world. Let the global community choose where they would prefer to receive their medical care, and people from around the world would line up at our borders.

Just like expenditures, we need to make the apples-to-apples comparison on outcomes. Infant mortality statistics in this country are skewed because other countries do not record the deaths of the low birth-weight newborns that we try to save in the U.S. Infant mortality is affected in significant ways by cultural and social factors, as well as individual behavior that has no direct relationship to the practice of medicine or whether patients have insurance. The death rates among children in Louisiana are the highest in the nation, and infant mortality rates in that state are the second highest in the U.S. But just 55 percent of children in Louisiana actually make it to the doctor's office for their recommended "Well-Child" visits despite the fact that 95 percent of children have insurance, mostly Medicaid. I have attached to my testimony a paper published by John Goodman of the National Center For Policy Analysis which addresses these international comparisons in more detail. The bottom line is that outcome for many types of cancer, heart disease, diabetes, and high blood pressure is clearly better in the U.S. than in the rest of the world.

As I noted in my introductory comments, we believe that allowing patients and physicians to enter into private contractual agreements is the single most important step we can take to reform the nation's medical care system.

Doing so will empower the patient to spend their own health care dollars and make their own health care decisions – regardless of third party payers like Medicare – as they see

fit, without constraint. Patients should be able to choose their physician, and they should be able to make decisions about their health care in concert with their physician.

Private contracting will promote transparency, accountability, and cost control at the individual level. Patients who are more directly involved in their health care will be better able to detect and prevent fraud and abuse. Medical expenditures can only be appropriately controlled and allocated when there is complete transparency and acknowledgement of necessity and value at the time of the patient-physician interaction.

Private contracting also will enhance access to medical care. Many physicians opt out of government health care plans because the payment systems do not cover the cost of providing care. If patients in these programs were given the opportunity to privately contract with the doctor of their choice, every patient would have access to every doctor. These patients and their physicians could then decide what care they need, and they could negotiate the fees for that care on an individual basis. The patient's unique health care insurance circumstances would serve as the baseline for that negotiation. This means the doctor could charge his or her full fee, a reduced fee, or no fee at all based on individual circumstances – an option currently not available under current government systems and prohibited in the discussion draft. As a bottom line, private contracting will preserve the kind of patient-physician relationship that has served as the foundation for the best medical care in the world. Moreover, restoring the right of patients and physicians to privately contract will help us attain the fiscal results our country desperately needs.

There are some elements of the discussion draft that we support. We appreciate the fact that the draft deals with the flawed and "unsustainable" Sustainable Growth Rate in a meaningful way. Rebasing the SGR is a necessary step in the right direction. That said, I would be remiss if I did not note that we remain concerned that the discussion draft includes language that would have us rely on a target-based system.

We support the emphasis on prevention and wellness as well as the timely payment of claims, transparency in the claims payment process, and administrative simplifications

such as a uniform claims form. We agree that the practice of primary care should be made more feasible, and we appreciate the provisions that facilitate the utilization of all available residency training slots.

However, we cannot support – and would actively oppose – the discussion draft. As I have noted, it is fundamentally flawed and based on faulty assumptions. We believe that it unleashes the heavy hand of the government to influence how we as physicians will treat our patients. We do not believe that the federal government, which serves as the single largest payer for medical care should replace the current methods for research and development or substitute the training and judgment of physicians, with federally controlled comparative effectiveness research. This simply is not in the best interest of our patients. We cannot achieve excellence in care by following government "quality" standards. Efficiency studies can seldom be applied directly to a given patient without considering that patient's unique circumstances. We're not talking about widgets here; we're talking about individual patients and individual circumstances. These circumstances require that physicians practice the art of medicine with the full knowledge of the science of medicine.

It's also worth noting that the discussion draft contains some new administrative reporting requirements and "gotcha" provisions that will drive the best and the brightest students into other professions. The administrative hassle factor associated with medicine has gotten to that point. The 2008 survey of 12,000 physicians by the Physician's Foundation revealed that 94% of doctors say the time they devote to non-clinical paperwork has increased in the last three years and 63% said that the same paperwork has caused them to spend less time per patient. A staggering 60% of doctors would not recommend medicine as a career to young people. [Executive Summary Attached]

I recently overheard a newly-trained physician express her frustration when she told a friend "As soon as I finish repaying my school loans, I will be getting out of medicine." My thoughts went to all of the patients she could help if she stayed in medicine, and how badly we need physicians in so many areas of our nation.

We believe that there is a clear need to change the way we finance medical care in this country. However, we believe that the private marketplace should remain the primary means of insurance for all non-disabled, working-age adults, and we believe that seniors should have more choices than those currently offered under Medicare. We have serious concerns that a government-sponsored health insurance program for working-age adults will invariably eliminate some or all private options. Remember that Medicare was originally introduced as an "option" for seniors, but today it has essentially become their only choice.

We oppose the bundling of physician payments. We believe this will drive a large wedge between patients and physicians much the same way as have capitated payments. In his recent address to the AMA, President Obama promoted a formal "team" approach to medical care – such as "accountable care organizations." Physicians have always embraced the value of working as a team when providing care. This is what medical and surgical residents are taught in hospitals. But physicians in private practice communities across the nation also work as part of a team, albeit in a variety of models. We strongly disagree that the basing payment on participation in a "team" created by the government is the appropriate model for payment and delivery systems.

As an early adopter, I see the incredible potential for electronic health records. But I also offer a word of caution when it comes to managing our expectations for EHR cost savings. We must also continue to take steps to safeguard patient privacy.

In terms of solutions, and as I have noted, we believe that the single most important step we can take to reform the medical care system is giving patients and physicians the right to enter into private contractual agreements.

We can also eliminate the obstacles to health care insurance for all Americans by changing the tax code. We can accomplish this by adopting a tax equity policy for the

purchase of insurance, by using pooling mechanisms for increased purchasing power, and by placing a greater emphasis on tax deductions and tax credits.

We must transform the health insurance model into one that's owned and controlled by patients. Most Americans receive their health care coverage through a third party, which means their health care decisions are influenced by their employer or the government. People should be able to purchase the health insurance product that best fits their individual needs. Doing so drives the accountability and flexibility needed to ensure that we maintain the quality of our care, while lowering costs. This approach would also eliminate the phenomenon of "pre-existing conditions" because individuals could carry their insurance with them for life, independent of their occupation or employer.

Finally, we can significantly reduce health care expenditures by enacting proven, effective medical liability reform measures that will eliminate the need for so-called "defensive medicine." Georgia serves as a great model. We passed significant tort reform in Georgia in 2005; claims are down by nearly 40 percent, professional liability insurance costs for physicians are down by 18 percent, and we're seeing fewer frivolous lawsuits. We've also seen professional liability insurance carriers come back into the state. The result? Increased access to affordable, quality health care.

I appreciate this opportunity to present the views of practicing physicians to you today. I'd be pleased to answer any questions.

States With More Health Care Spending Have Better-Quality Health Care: Lessons About Medicare

Health care spending is an important contributor to quality, but the determinants of quality reach more deeply into a community's sociodemographic fabric.

by Richard A. Cooper

ABSTRACT: Based on broad measures of health system quality and performance, states with more total health spending per capita have better-quality care. This fact contrasts with a previous finding that states with higher Medicare spending per enrollee have poorer-quality care. However, quality results from the total funds available and not from Medicare or any single payer. Moreover, Medicare payments are disproportionately high in states that have a disproportionately large social burden and low health care spending overall. These and other vagaries of Medicare spending pose critical challenges to research that depends on Medicare spending to define regional variation in health care. [*Health Affairs* 28, no. 1 (2009): w103–w115 (published online 4 December 2008; 10.1377/hlthaff.28.1.w103)]

HEALTH CARE SPENDING CONTINUES TO GROW at a pace that exceeds the overall rate of economic expansion. This creates an ever-stronger imperative to understand the dynamics of its growth and the value of this spending. An important source of information that bears on this problem is the extensive base of Medicare administrative data maintained by the Centers for Medicare and Medicaid Services (CMS).[1] Drawing on this source, researchers associated with the *Dartmouth Atlas* project have found much variation in Medicare spending per enrollee across regions of the country and have concluded that higher spending is not associated with better-quality health care.[2] Indeed, at the state level, more Medicare spending per enrollee is associated with poorer health care quality.[3]

The notion that quality is poorer in the face of more health care spending is extremely important. But is it correct? Answering this question requires answering

Richard Cooper (cooperra@wharton.upenn.edu) is a professor of medicine in the Leonard Davis Institute at the Wharton School, University of Pennsylvania, in Philadelphia.

DOI 10.1377/hlthaff.28.1.w103 ©2008 *Project HOPE–The People-to-People Health Foundation, Inc.*

three. First, does Medicare spending provide a valid assessment of health care spending overall? Second, are commonly used "quality" standards valid measures of the value of health care spending? And third, is regional variation in Medicare spending a valid tool for assessing the dynamics of the health care system?

The answer to the first question is "no." Medicare spending per enrollee correlates poorly with total health care spending per capita.[4] Although "quality," as measured by broad indices, correlates negatively with Medicare spending, this paper shows that quality is better in states with higher total per capita health care spending. Medicare cannot be used as a proxy for health care spending overall.

The answer to the second question is also "no." Although more health care spending correlates with better quality, causality between health care spending and quality should not be inferred, since, as described below, both spending and quality also correlate with a host of other parameters that reflect the sociodemographic context in which health care resides.

And finally, is regional variation in Medicare spending a valid metric of health system performance? The answer, again, is "no," which calls into question the vast array of studies that depend on cross-sectional analyses of Medicare spending to assess regional variation in health care.

Study Data And Methods

Estimates of health care spending for 2000 and 2004 were obtained from the CMS, and data on spending for 2000 were also obtained from Katherine Baicker.[5] The latter had been adjusted for age, sex, race, and cost of living. Population estimates were from the Census Bureau, and estimates of per capita income were from the Bureau of Economic Analysis.[6] Data at the state level concerning race and ethnicity, economic status, mortality rates, poverty rates, insurance status, K–12 education spending, prison incarceration rates, and related sociodemographic characteristics were obtained from the Commonwealth Fund, the Henry J. Kaiser Family Foundation, the Census Bureau, and other public sources.[7] Relationships were analyzed by means of linear regressions and expressed as Pearson correlation coefficients.[8] All correlations that were not significant at the 0.05 level are so indicated. In general, correlations above 0.30 were significant at the 0.01 level, and correlations between 0.25 and 0.30 were significant at the 0.05 level.

Quality was expressed as state rankings of health system performance, as developed by Stephen Jencks and colleagues and used in the previous study by Baicker and Amitabh Chandra, and as developed by the Commonwealth Fund for its recent State Scorecard.[9] The Jencks quality rankings for 1998 and 2000, which correlated closely with each other ($r = 0.91$), were averaged. Most items in the Jencks scale relate to screening and prevention or to processes of care (for example, appropriate use of discharge medications), and only one-third relate directly to medical care for conditions such as heart disease, stroke, or pneumonia. Similarly, most items in the Commonwealth Fund's scale, which was constructed from data

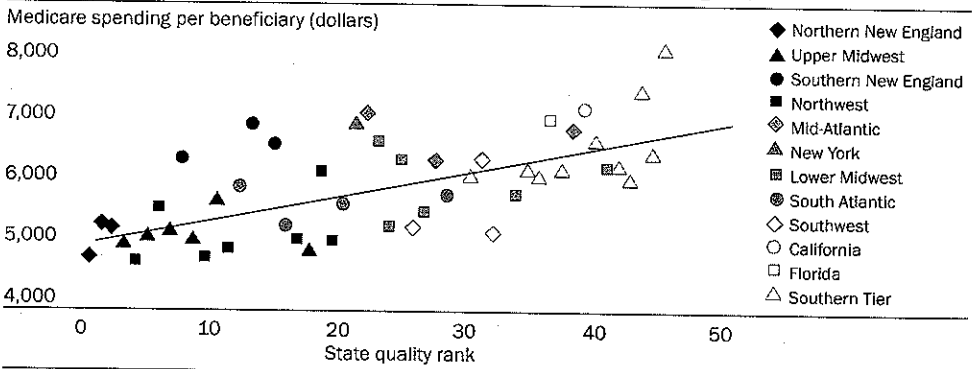
gathered in 2006, relate to screening, prevention, access, referral, satisfaction, equity, and custodial care, and only a few, such as postoperative care and the treatment of acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia, relate directly to the goals of most health care expenditures. The similarity of the Jencks and Commonwealth scales is evident by the strong correlation between the state quality rankings obtained with each ($r = 0.85$). Both ranking systems assign higher numbers to states with poor quality. Therefore, positive correlations between spending and quality would indicate that more spending is associated with lesser quality.

For descriptive purposes, states were grouped as follows: Northern New England (ME, NH, VT); Southern New England (MA, CT, RI); Mid-Atlantic (NJ, PA, MD); Upper Midwest (WI, MN, IA, ND, SD, NE); Northwest (WA, OR, UT, ID, MT, WY, CO); Lower Midwest (KS, MO, IN, IL, MI, OH); South Atlantic (DE, VA, NC, SC); Southern Tier (WV, TN, KY, GA, AL, AR, MS, LA, OK, TX); and Southwest (AZ, NV, NM).Because of their size and prominence, California, Florida, and New York are shown individually. The District of Columbia, Alaska, and Hawaii were excluded.

Study Results

■ **Quality and Medicare spending.** Using the Jencks quality scale and adjusted Medicare spending data from 2000, we observed a strong correlation between Medicare spending per enrollee and state quality rankings ($r = 0.65$; Exhibit 1), with poorer quality associated with higher spending, as previously reported.[10] Similar correlations between spending and quality, as measured by the Jencks scale, were

EXHIBIT 1
Quality And Medicare Spending Per Beneficiary, By Census Region, 2000



SOURCES: Medicare spending data from 2000, adjusted for age, sex, race, and cost of living, were obtained from Katherine Baicker and were previously published: K. Baicker and A. Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* 23 (2004): w184–w197. Quality rankings are the averages from S.F. Jencks et al., "Quality of Medical Care Delivered to Medicare Beneficiaries," *Journal of the American Medical Association* 284, no. 13 (2000): 1670–1676; and S.F. Jencks, E.D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTES: Correlation coefficient = 0.65. Lower numbers on the quality rank indicate better quality.

observed with unadjusted Medicare spending data from both 2000 and 2004, and significant correlations between more Medicare spending and poorer state quality rankings were also obtained using the Commonwealth quality scale (Exhibit 2). Thus, over a period of years and with two different (although overlapping) quality scales, there was a consistent association between more Medicare spending per enrollee and poorer state quality rankings.

■ **Quality and total health care spending.** A very different picture emerges when state quality rankings are compared with total health care spending per capita. Using unadjusted spending data from 2004, we observed strong correlations between total per capita spending and better quality, with either the Jencks or the Commonwealth scales (Exhibit 2). Note that because better quality is associated with a lower numerical ranking, the signs of these correlations are negative. Correlations were even stronger when Medicare spending and enrollees were excluded and spending per capita for the non-Medicare portion of the population was compared with quality, using the Jencks ($r = -0.47$) or Commonwealth ($r = -0.62$) scales (Exhibits 2 and 3). Thus, while more Medicare spending is associated with poorer health care quality at the state level, more non-Medicare spending and more total

EXHIBIT 2
Health Care Spending Correlations

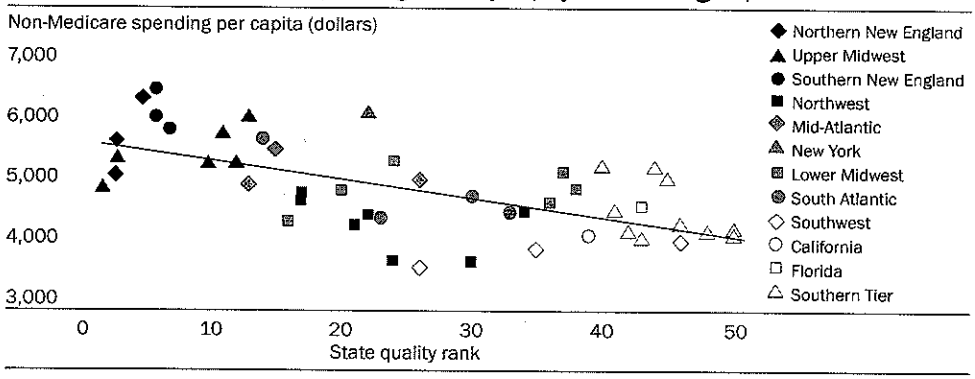
	Medicare 2000 (adjusted)	Medicare 2000 (unadjusted)	Medicare 2004 (unadjusted)	Non-Medicare 2004 (unadjusted)	Total 2004 (unadjusted)	Ratio 2004
Jencks quality rank	0.65	0.53	0.44	−0.47	−0.34	0.69
Commonwealth quality rank	0.41	0.28	0.25	−0.62	−0.51	0.64
Percent black plus Latino	0.59	0.59	0.52	−0.46	−0.34	0.76
Percent non-Hispanic white	−0.56	−0.53	−0.45	0.44	0.34	−0.69
Percent poverty	0.26[a]	0.10[a]	0.03[a]	−0.41	−0.37	0.35
Percent DSH	0.42	0.46	0.40	−0.17[a]	−0.04[a]	0.45
Percent employer-sponsored health insurance	−0.25[a]	0.01[a]	0.09[a]	0.39	0.38	−0.27
Medicaid spending per enrollee	0.00[a]	0.12[a]	0.10[a]	0.73	0.70	−0.49
Percent uninsured	0.38	0.22[a]	0.30	−0.62	−0.56	0.60
Percent of adults with usual source of care	−0.05[a]	0.13[a]	0.13[a]	0.55	0.56	−0.36
Infant mortality rate	0.32	0.25	0.29	−0.27	−0.17[a]	0.39
Preventable mortality rate, white	0.46	0.38	0.37	−0.25	−0.14[a]	0.46
Preventable mortality rate, black	0.52	0.34	0.36	−0.22	−0.13[a]	0.45
K–12 spending per pupil	0.21	0.38	0.22	0.68	0.66	−0.37
Prison incarceration rate	0.57	0.53	0.45	−0.30	−0.20[a]	0.60

SOURCES: See Notes 5, 6, and 7 in text.

NOTES: Correlations are expressed as Pearson coefficients. DSH is disproportionate-share hospital.

[a] Not significant at alpha = 0.05.

EXHIBIT 3
Quality And Non-Medicare Spending Per Capita, By Census Region, 2004



SOURCES: Health spending data for 2004 were obtained from Centers for Medicare and Medicaid Services, "Health Expenditures by State of Provider, 1991–2004," September 2007, http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp (accessed 8 October 2008). Quality rankings were obtained from Commonwealth Commission on a High Performance Health System, *Aiming Higher—Results from a State Scorecard on Health System Performance* (New York: Commonwealth Fund, 2007).
NOTES: Correlation coefficient = 0.62. Lower numbers on the quality rank indicate better quality.

spending are associated with better quality.

The fact that Medicare and non-Medicare spending behave differently with respect to quality is reflected most simply in the associated fact that although both sources of reimbursement vary among states by approximately 30 percent, the relationship between the two channels of payment was not significant ($r = 0.19$), as noted previously.[11]

This pattern of divergence extends to other health-related parameters. For example, preventable mortality among both blacks and whites is greater in states with higher Medicare spending and less in states with higher non-Medicare spending (Exhibit 2). Infant mortality follows the same pattern. More adults in states with higher non-Medicare spending report having a usual source of care ($r = 0.55$), while there is no association between Medicare spending and the existence of a usual source of care. Correspondingly, the frequency with which Medicare patients obtain timely mammography correlates positively with non-Medicare spending ($r = 0.44$) and negatively with Medicare spending ($r = -0.37$).[12]

■ **Regional relationships.** These differences in Medicare and non-Medicare spending and their relation to quality are not randomly distributed geographically. Rather, they follow distinct regional patterns (Exhibits 1 and 3). Quality is best in New England, the Upper Midwest, and the Northwest, and it is poorest in the Southern Tier states, extending from Georgia and Florida across to Texas and Oklahoma, and in California.

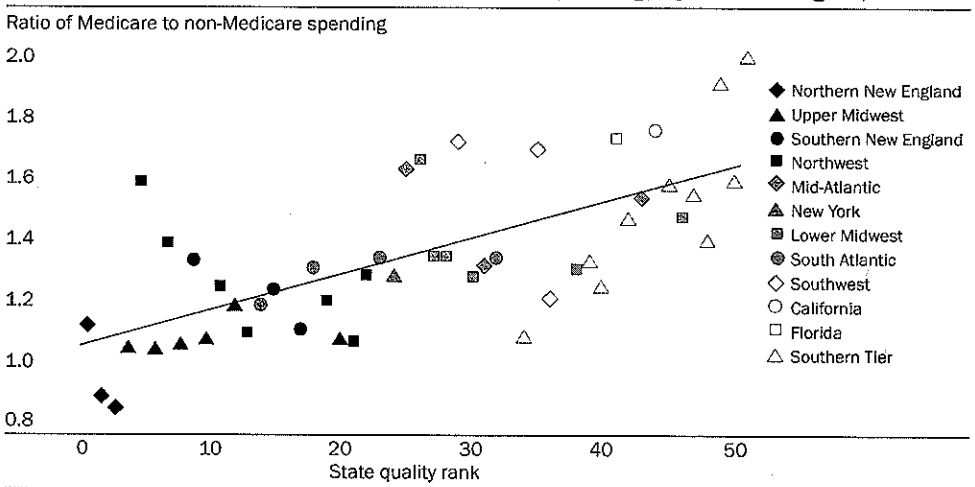
Medicare spending is lowest in Northern New England and the Upper Midwest, where quality is high, and these states have among the highest non-Medicare spending. Conversely, Medicare spending are highest in the Southern

Tier states and in California, where quality is poor, and these states have among the lowest rates of non-Medicare spending. Also, Southern New England and New York, where quality is average to high, have high spending through both Medicare and non-Medicare channels, whereas the Northwest, with similar quality, has lower spending through both channels.

The contrast between Medicare and non-Medicare spending in relation to quality was most pronounced when the data were expressed as a correlation between quality and the ratio of Medicare to non-Medicare spending (Exhibits 2 and 4). Ratios closest to 1.0 tend to be associated with the best quality, and they were found in Northern New England and the Upper Midwest (Exhibit 4). Conversely, ratios closest to 2.0, representing disproportionate Medicare spending, were found principally in the South, and they were associated with the poorest quality. The overall polarity displayed in Exhibit 3 starkly separates regions of the country in terms of spending patterns and quality.

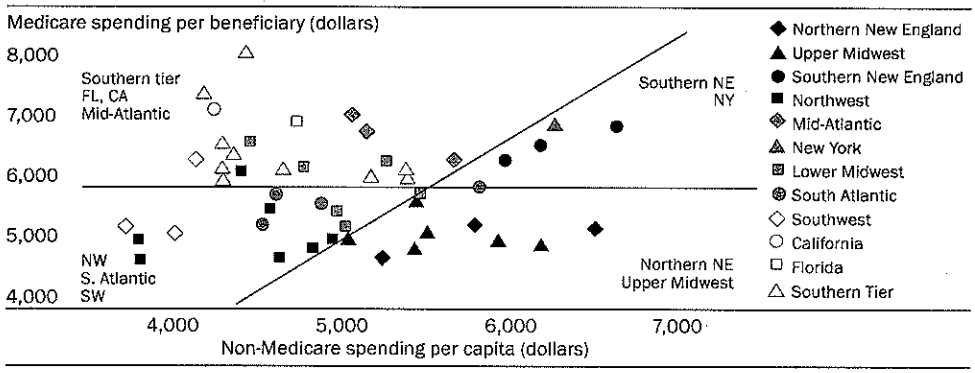
■ **Medicare versus non-Medicare spending.** Exhibit 5 independently displays Medicare and non-Medicare spending in the various states. Four general patterns were observed: low/low—states that had both low Medicare and low non-Medicare spending were principally in the Northwest, Southwest, and South Atlantic regions. High/high—states with high levels of spending through both channels included New York and Southern New England. Low Medicare/high non-Medicare—like Southern New England, Northern New England had high levels of non-Medicare

EXHIBIT 4
Quality And Ratio Of Medicare To Non-Medicare Spending, By Census Region, 2004



SOURCES: Health spending data for 2004 were obtained from Centers for Medicare and Medicaid Services, "Health Expenditures by State of Provider, 1991–2004," September 2007, http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp (accessed 8 October 2008). State quality rankings were obtained from Commonwealth Commission on a High Performance Health System, *Aiming Higher—Results from a State Scorecard on Health System Performance* (New York: Commonwealth Fund, 2007).
NOTES: Correlation coefficient = 0.69. Lower numbers on the quality rank indicate better quality.

EXHIBIT 5
Medicare Spending Per Beneficiary And Non-Medicare Spending Per Capita, By Census Region, 2004



SOURCES: Health spending data for 2004 were obtained from Centers for Medicare and Medicaid Services, "Health Expenditures by State of Provider, 1991–2004," September 2007, http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp (accessed 8 October 2008).

spending, but Medicare spending was low, and this pattern was also found in the Upper Midwest. High Medicare/low non-Medicare—a pattern of higher Medicare spending in association with lower non-Medicare spending was found in states within the Southern Tier, including Florida; in California; and in the populous Mid-Atlantic states.

Thus, high Medicare spending tends to follow a band extending from the California across the Southern Tier and up the East Coast through New York into Southern New England, a pattern that is evident both at the state level and at the level of Hospital Referral Regions (HRRs).[13] However, because Medicare and non-Medicare spending vary independently, some states with high levels of Medicare spending have low levels of non-Medicare spending, whereas others have high levels of both. Examples of the former include Texas, Louisiana, Florida, and Mississippi, while examples of the latter include Massachusetts, Connecticut, and New York. Aggregating and averaging individuals from these high-Medicare-spending states, some with high total spending and other with low total spending, as has been done in studies reported by the Dartmouth group, creates unintelligible units of observation.[14]

■ **Sociodemographic correlates.** Insight into the causes of this divergence between Medicare and non-Medicare spending is provided by various sociodemographic correlates. States with higher non-Medicare spending tended to have lower percentages of blacks and Latinos and higher percentages of non-Hispanic whites; lower percentages of individuals below the poverty level and higher percentages of workers in professional and technical jobs; and lower percentages of uninsured people and higher percentages covered by employment-sponsored health insurance (Exhibit 2). Conversely, states with higher Medicare spending per enrollee tended to have larger percentages of individuals who are black and Latino and smaller per-

centages who are non-Hispanic white; higher percentages of uninsured people; and, correspondingly, higher percentages of Medicare reimbursement based on disproportionate-share hospital (DSH) funding. Assessing relationships such as these in terms of the ratio of Medicare to non-Medicare spending yielded even stronger correlations (Exhibit 2). Examples include the positive correlations between the Medicare to non-Medicare ratio and the states' percentages of blacks and Latinos ($r = 0.76$) and uninsured people ($r = 0.60$).

Additional insight into community differences that correspond to Medicare and non-Medicare reimbursement can be found by examining characteristics that reflect other aspects of a community's social strengths. Two such characteristics are its investment in K–12 education and its rates of prison incarceration. Non-Medicare spending correlated strongly and positively with per pupil spending for K–12 education ($r = 0.68$) and negatively with per capita rates of prison incarceration, whereas Medicare spending per enrollee correlated weakly with K–12 expenditures but had a strong and positive correlation with prison incarceration rates (Exhibit 2).

■ **Sociodemographic correlates of quality.** Demographic characteristics, such as those described above, relate independently to quality (Exhibit 6). For example, quality is poorer in states where higher percentages of the population are black and Latino, uninsured, in poverty, and in prison; and mortality is higher in such states by

EXHIBIT 6
Health Care Quality Correlations

	Jencks quality rank	Commonwealth quality rank
Percent black plus Latino	0.65	0.56
Percent non-Hispanic white	−0.63	−0.51
Percent poverty	0.60	0.58
Percent Medicare disability	0.48	0.58
Percent DSH	0.58	0.50
Percent uninsured	0.60	0.75
Medicaid spending per enrollee	−0.45	−0.58
Percent employer-sponsored health insurance	−0.49	−0.62
Percent adults with usual source of care	−0.30	−0.51
K–12 spending per pupil	−0.31	−0.53
Prison incarceration rate	0.59	0.46
Per capita income	−0.33	−0.51
Age-adjusted mortality, all	0.66	0.75
Age-adjusted mortality, white	0.63	0.76
Age-adjusted mortality, black	0.58	0.55
Infant mortality rate	0.58	0.55
Preventable mortality rate, white	0.72	0.71
Preventable mortality rate, black	0.64	0.53

SOURCES: See Notes 5, 6, and 7 in text.
NOTES: Correlations are expressed as Pearson coefficients. DSH is disproportionate-share hospital.

all measures. Conversely, quality is better in states where higher percentages of populations are non-Hispanic white, where more have employment-sponsored insurance, and where more is spent on K–12 education. Per capita income correlates positively with better quality. Thus, a web of economic, demographic, and health spending patterns independently and collectively unite quality, health care spending, and social structure. The picture that emerges is that states with higher Medicare spending per enrollee tend to have a higher social burden and poorer quality, while states with more non-Medicare spending have greater economic and social strength and better quality.

■ **Medicare's special characteristics.** It is important to note that Medicare reimbursement accounts for only half of the total spending for the care of Medicare enrollees, with the rest provided through either other public programs (such as through Medicaid or the Department of Veterans Affairs) or private sources (such as through supplemental insurance or out-of-pocket payments).[15] In addition, although reimbursement through Medicaid and other local and state programs and through employers is generally influenced by local economic conditions, Medicare reimbursement results from policies at the national level that are designed not only to reimburse caregivers but also to achieve particular social or political goals.[16] These features of Medicare reimbursement help explain why it is a poor proxy for health care spending overall.

Disability. Although Medicare is generally thought of as the health plan for older Americans, 19 percent of Medicare beneficiaries in 2005 were under age sixty-five, up from 15 percent seven years earlier. Most nonelderly beneficiaries are covered under Social Security disability, but this category also includes 300,000 people in the end-stage renal disease (ESRD) program. The percentage of enrollees who are on disability varies widely among the states, from 10 percent in North Dakota to 25 percent in Mississippi, and these percentages correlate directly with lower quality and higher rates of preventable mortality (Exhibit 6).

DSH. DSH payments are allotted to hospitals that provide disproportionate amounts of care for the poor. These payments account for approximately 3 percent of total Medicare reimbursement. This amount does not distort the relationships discussed herein; however, it is noteworthy that states in which DSH payments account for a higher percentage of Medicare reimbursement have higher total Medicare spending per enrollee and lower-quality health care (Exhibits 2 and 6).

Graduate medical education. Medicare reimbursement also includes the direct costs of medical education (DME) and the associated indirect medical education (IME) payments, which are meant to reimburse teaching hospitals for other unusual costs. These, too, differ among states.

Input costs. Another factor that influences reimbursement is the manner in which Medicare adjusts its payments for input costs. Although the health care component of the cost of living index varies among the states by approximately 10 percent, Medicare's wage index, which adjusts its payments to hospitals for local la-

bor costs, varies by more than 20 percent, often because of congressional mandates. Indeed, given the plethora of issues and inconsistencies that surround the current wage index, the Medicare Payment Advisory Commission (MedPAC) has recommended changes in methodology, which Congress has directed the Department of Health and Human Services to consider for fiscal year 2009.[17]

■ **Economic correlates of non-Medicare spending.** Medicaid and employer-sponsored insurance are the two largest components of non-Medicare spending, and both relate to fiscal resources in the community. The effects of state and local economic considerations on eligibility criteria and reimbursement levels for Medicaid are reflected by a strong correlation between state per capita income and Medicaid spending per enrollee ($r = 0.59$). Conversely, the percentage of the population that is uninsured correlates inversely with state per capita income ($r = -0.35$).

Similar considerations apply to the prevalence of employment-sponsored insurance, which correlates strongly with state per capita income ($r = 0.60$). At the level of Metropolitan Statistical Areas (MSAs), Richard Kronick and colleagues have found that both personal income and aggregate communal income are important.[18] They attributed two-thirds of the likelihood that workers would be covered by employer-sponsored insurance to the workers' individual characteristics (principally income) and one-third to communal characteristics (principally aggregate income in the same MSA). Ultimately, the interplay of both was most strongly predictive. These factors spill over to supplemental insurance, which is less than half as prevalent among Medicare enrollees who are black or poor.[19]

Concluding Comments

■ **Quality depends on total health care spending.** Higher Medicare spending per enrollee correlates with poorer-quality health care at the state level, which has led members of the Dartmouth group to conclude that higher Medicare spending is attributable to waste and inefficiency.[20] However, the observed relationship between Medicare spending and quality is principally due to the fact that many states in the South have high Medicare spending per enrollee but low health care spending per capita, and their poor quality correlates with their overall low levels of health care spending. Medicare patients within a given hospital or health care market would not be expected to experience better or worse quality because of the payment levels from Medicare alone. Staffing decisions, the availability of information technology, preventive services, and other investments that contribute to quality and system performance depend on total funds available, not on the funds from any particular reimbursement stream. In that light, it seems reasonable to expect better quality in states with higher per capita spending overall, as was observed.

■ **Quality relates to a broad array of sociodemographic characteristics.** The relationship between health care spending and quality at the state level may have elements of causality. It seems likely that more spending would lead to stronger local health care systems. However, quality, as assessed in this and similar studies, reflects

"The evidence that Medicare spending is a poor proxy for overall health care spending seems clear."

a broad set of health care system attributes, whereas most health care spending is directed more narrowly to hospital and physician services. Moreover, quality rankings correlate not only with health care spending but also with other sociodemographic characteristics, such as income, race, and spending for K–12 education. Similar relationships have been observed between spending for education and other public services and all-cause mortality.[21] These observations suggest that although health care spending is an important contributor to quality, the determinants of quality reach more deeply into the sociodemographic fabric of the community.

■ **Medicare spending among states is a misleading indicator.** Although levels of non-Medicare spending relate to services provided, Medicare reimbursement is influenced by other factors. Some are created by legislative and administrative mandates that reward particular regions, institutions, or contractors—a process that Bruce Vladeck has termed "interest-group politics."[22] Others are in response to sociodemographic differences, such as those noted above. David Cutler and Louise Sheiner have attributed two-thirds of the variation in Medicare spending to health status and demographics, and MedPAC has attributed 55 percent to demographics and practice patterns.[23] Indeed, Medicare is a major means of income redistribution among areas of the country. Considerations such as these led Daniel Zabinski and Robert Reischauer to conclude that Medicare spending at the state level is "misleading" for analyzing variation in the amount of care provided to beneficiaries.[24]

■ **Medicare spending is a poor proxy for health care spending overall.** The evidence that Medicare spending is a poor proxy for overall health care spending seems clear. First, there is no significant correlation between Medicare and non-Medicare spending. Second, although more Medicare spending per enrollee correlates with poorer health care quality, more non-Medicare spending per capita correlates with better quality. Third, although more Medicare spending correlates with community characteristics that reflect greater social needs, more non-Medicare spending correlates with characteristics that reflect more economic strength.

Observations such as these lead inevitably to the conclusion that regional variation in Medicare spending does not reflect the behavior of the health care system overall. This is a critical point, since Medicare spending data form the basis for many studies of regional variation, including those that are associated with the *Dartmouth Atlas* project.[25] The supposition in each is that Medicare is a proxy for the whole. Indeed, Dartmouth researchers recently claimed that "state-level Medicare spending is closely correlated with overall per capita spending."[26] Yet the cited source stated unequivocally that "Medicare spending does not explain much of the variation in total per capita personal health care spending."[27] Thus, the vagaries of Medicare spending across the nation pose critical challenges to any re-

search that depends on this index of spending to define the behavior of physician practices, hospitals, or the health care system overall.

The dual realization that more health care spending at the state level is associated with better-quality health care and that Medicare spending, which bears an inverse relationship to quality, is not a proxy for the whole should refocus thinking about the impact of health care spending on society, as politicians and the public prepare to address the vexing issues of national health care reform.

An earlier version of this paper was presented at the National Health Policy Forum, in Washington, D.C., 15 February 2007; at the Nineteenth Princeton Conference, in Princeton, New Jersey, 23 April 2007; and at the Association of American Medical Colleges (AAMC) Workforce Conference, in Washington, D.C., 1 May 2008.

NOTES

1. Centers for Medicare and Medicaid Services, "Health Expenditures by State of Residence, 1991–2004," September 2007, http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp (accessed 15 January 2008).
2. J.S. Skinner, D.O. Staiger, and E.S. Fisher, "Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction," *Health Affairs* 25 (2006): w34–w47 (published online 7 February 2006; 10.1377/hlthaff.25.w34); E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* 138, no. 4 (2003): 273–287; E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138, no. 4 (2003): 288–298; and Center for the Evaluative Clinical Sciences, Dartmouth Medical School, "Supply-Sensitive Care," *Dartmouth Atlas* Project Topic Brief, 2007, http://www.dartmouthatlas.org (accessed 15 December 2007).
3. K. Baicker and A. Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* 23 (2004): w184–w197 (published online 7 April 2004; 10.1377/hlthaff.w4.184).
4. A.B. Martin et al., "Health Spending by State of Residence, 1991–2004," *Health Affairs* 26, no. 6 (2007): w651–w663 (published online 18 September 2007; 10.1377/hlthaff.26.6.w651).
5. CMS, "Health Expenditures"; and Baicker and Chandra, "Medicare Spending." Adjusted Medicare data were kindly provided by Katherine Baicker. Details about the adjustments made can be found in Baicker and Chandra, "Medicare Spending."
6. U.S. Census Bureau, "American FactFinder," http://factfinder.census.gov (accessed 15 January 2008); and Bureau of Economic Analysis, "Regional Economic Accounts," http://www.bea.gov/regional/index.htm (accessed 15 January 2008).
7. Commonwealth Commission on a High Performance Health System, *Aiming Higher—Results from a State Scorecard on Health System Performance* (New York: Commonwealth Fund, 2007); Henry J. Kaiser Family Foundation, "State Health Facts," http://statehealthfacts.org/index.jsp (accessed 15 January 2008); National Archives of Criminal Justice Data, "Prison and Jail Inmates at Midyear 2005," http://www.icpsr.umich.edu/NACJD (accessed 15 January 2008); U.S. Census Bureau, *Statistical Abstract of the United States, 2000–1995*, http://www.census.gov/prod/www/abs/statab1995_2000.html (accessed 7 October 2008); and National Center for Education Statistics, "Student Membership and Current Expenditures per Pupil for Public Elementary and Secondary Education, 2006," http://nces.ed.gov/pubs2008/expenditures/xls/table_03.xls (accessed 12 May 2008).
8. E.W. Corty, *Using and Interpreting Statistics: A Practical Text for the Health, Behavioral, and Social Sciences* (St. Louis: Mosby, 2006).
9. S.F. Jencks et al., "Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels," *Journal of the American Medical Association* 284, no. 13 (2000): 1670–1676; S.F. Jencks, E.D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312; Commonwealth Commission, *Aiming Higher*; and Baicker and Chandra, "Medicare Spending."
10. Baicker and Chandra, "Medicare Spending."

11. Martin et al., "Health Spending."
12. A negative association between Medicare spending and timely mammography was reported by Baicker and Chandra, "Medicare Spending." Mammography data were kindly provided by Katherine Baicker.
13. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1."
14. Ibid.; and Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 2."
15. C. Caplan, "What Share of Beneficiaries' Total Health Care Costs Does Medicare Pay?" Data Digest no. 78 (Washington: AARP Public Policy Institute, September 2002).
16. R. Kronick, T. Gilmer, and T. Rice, "The Kindness of Strangers: Community Effects on the Rate of Employer Coverage," *Health Affairs* 23 (2004): 328–340 (published online 2 June 2004; 10.1377/hlthaff.w4.328); and B.C. Vladeck, "The Political Economy of Medicare," *Health Affairs* 18, no. 1 (1999): 22–36.
17. Medicare Payment Advisory Commission, "An Alternative Method to Compute the Wage Index," chap. 6 in *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington: MedPAC, June 2007); and *Tax Relief and Health Care Act of 2006*, HR 6111, PL 109-432, 109th Cong., 2nd sess., 20 December 2006.
18. Kronick et al., "The Kindness of Strangers."
19. M.A. Laschober et al., "Trends In Medicare Supplemental Insurance and Prescription Drug Coverage, 1996–1999," *Health Affairs* 21 (2002): w127–w138 (published online 27 February 2002; 10.1377/hlthaff.w2.127).
20. J.E. Wennberg, E.S. Fisher, and J.S. Skinner, "Geography and the Debate over Medicare Reform," *Health Affairs* 21 (2002): w96–w114 (published online 13 February 2002; 10.1377/hlthaff.w2.96); Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1;" and Baicker and Chandra, "Medicare Spending."
21. J.R. Dunn, B. Burgess, and N.A. Ross, "Income Distribution, Public Services Expenditures, and All Cause Mortality in U.S. States," *Journal of Epidemiology and Community Health* 59, no. 9 (2005): 768–774.
22. Vladeck, "The Political Economy of Medicare."
23. D.M. Cutler and L. Sheiner, "The Geography of Medicare," *American Economic Review* 89, no. 2 (1999): 228–233; and MedPAC, *Report to the Congress: Variation and Innovation in Medicare* (Washington: MedPAC, June 2003).
24. D. Zabinski and R. Reischauer, "Geographic Variation in Per Beneficiary Medicare Expenditures, 2003," Presentation at the Tenth Princeton Conference, 2003, http://council.brandeis.edu/pubs/Prince10/Reischauer-Zabinsky%20slides.pdf (accessed 15 May 2008).
25. Wennberg et al., "Geography"; and Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1."
26. B. Sirovich et al., "Discretionary Decision Making by Primary Care Physicians and the Cost of U.S. Health Care," *Health Affairs* 27, no. 3 (2008): 813–823.
27. Martin et al., "Health Spending."

ABSTRACT

Many arguments for the superiority of other health care systems have been repeated often: the United States spends more than any other country, but its health outcomes are often worse. Whereas no one is ever denied care because of an inability to pay in countries with universal coverage, as many as 18,000 people in the U.S. die each year because they are uninsured and more than half of all bankruptcies are caused by medical debts. Also, other countries avoid our high administrative costs.

Yet these and other assertions are debatable. Some are demonstrably false.

Health Care Reform: Do Other Countries Have the Answers?

John C. Goodman
National Center for Policy Analysis

Linda Gorman
Independence Institute

Devon Herrick
National Center for Policy Analysis

Robert M. Sade
Department of Surgery and Institute of Human Values in Health Care,
Medical University of South Carolina

The health care systems of all developed countries face three unrelenting problems: rising costs, inadequate quality, and incomplete access to care. Much analysis published in medical journals suggests that other countries have found superior solutions to these problems.[1] This conclusion is at odds with economic research that is published in journals physicians seldom read, using methodologies that are unfamiliar to physicians. In this essay, we attempt to shed light on topics frequently discussed in proposals for health care reform, drawing on the relevant medical and economics literature.

Does the United States Spend Too Much on Health Care?

International statistics show that 2005 United States (US) per capita health care spending was 2.3 times greater than the median Organization for Economic Cooperation and Development (OECD) country ($6,401 vs. $2,759, based on purchasing power parity) and 1.5 times larger than Norway, the country that followed Luxembourg in the spending ranking.[2] However, normal market forces have been so suppressed throughout the developed world that purchasers rarely see a real price for any medical service. As a result, summing over all transactions produces aggregate numbers in which one can have little confidence. In addition, other countries more aggressively disguise costs, especially by suppressing provider incomes.

Economists have long known that international health care spending comparisons are fraught with potential error. Even for uncomplicated dental fillings, reimbursement data underestimate total costs by 50% in nine European countries.[3] Countries account for long term care and out-of-pocket spending differently. The accounting treatment of overhead and capital costs also varies.[4] An OECD project to harmonize national accounting methods began in 2000,

but even when methods are harmonized, the choice of a price adjustment method can alter hospital cost estimates by as much as 400%.[5]

The US compares more favorably when real resources are measured rather than monetary accounts. Per capita, the US uses fewer physicians, nurses, hospital beds, physician visits, and hospitals days than the median OECD country.[6]

Even taking the monetary totals at their face value, the US has been neither worse nor better than the rest of the developed world at controlling expenditure growth. The average annual rate of growth of real per capita US health care spending is slightly below OECD average over the last decade (3.7% vs. 3.8%), and over the past four decades (4.4% vs. 4.5%).[7] Despite common perceptions, a country's financing method—public vs. private financing, general revenue vs. payroll taxes, third-party vs. out-of-pocket spending—is unrelated to its ability to control spending.[8]

For the US, the practical question is, can the adoption of another country's health care system offer a reasonable chance of improving US private sector methods? An answer in the negative is suggested by a comparison of the British National Health Service and California's Kaiser Permanente found that Kaiser provided more comprehensive and convenient primary care and more rapid access to specialists for roughly the same cost.[9]

Finally, international spending comparisons typically ignore costs generated by limits on supply. In 2002-2004, dialysis patients waited 16 days for permanent blood vessel access in the US, 20 days in Europe, and 62 days in Canada.[10] Waiting for care has economic costs in terms of sick pay and lost productivity, as well as negative health consequences. In the late 1990s, an estimated 5 to 10% of English waiting list patients were on sick leave. Norway is trying to reduce waiting times for patients "in order to reduce the cost of sickness benefits." Finland

calculates that the cost of waiting (sickness benefits, medicines, and social welfare expenses) can exceed the cost of treatment.[11]

Are US Outcomes No Better and in Some Respects Worse Than Those of Other Nations?

Analyses that answer this question in the affirmative are often based on data showing that US life expectancy is similar to that of other developed countries and that its infant mortality rate is among the highest.[12] Yet within the US, life expectancy at birth varies enormously among racial and ethnic groups, from state to state, and across US counties.[13] These differences often are attributed to such lifestyle choices as diet, exercise and smoking rather than to differences in the quality of health care.[14] Similarly, US infant mortality varies by a factor of two or three to one across racial and ethnic groups, across the largest cities, and across the states for reasons apparently having little to do with health care.[15] The low US international ranking reflects national differences in the definition of a live birth.[16] Eberstat finds that US infants, stratified by birthweight, have a high likelihood of survival, regardless of race or economic circumstances.[17]

Health care likely plays a leading role in determining outcomes for diseases such as cancer, diabetes, and hypertension. Comparing cancer outcomes, the largest international study to date found that the five-year survival rate for all types of cancer among both men and women was higher in the US than in Europe.[18] US women have a 63% chance of living at least five years after a cancer diagnosis, compared with 56% for European women. Survival after diagnosis of breast cancer was 90% and 79%, respectively. Men in the US have a five-year survival rate of 66%, compared to only 47% for European men. Survival after diagnosis of prostate cancer was 99% and 78%, respectively.[19]

Higher US spending on prescription drugs may explain why there is a steeper increase in blood pressure with advancing age in Europe and a 60% higher prevalence of hypertension. [20] While half of all diabetics have high blood pressure, it is controlled in 36% of US cases compared with only 9% in Canada.[21] The rate of adverse events in US hospitals is only about half that in England, Australia, and New Zealand.[22] The aggressive treatment offered US cardiac patients apparently improves survival and functioning compared with Canadian patients.[23] Fewer health and disability related problems occur among US spinal cord injury patients than among Canadian and British patients.[24]

The US has better relative survival rates than Norway for colorectal and breast cancer, lower rates of vaccine-preventable pertussis, measles, and Hepatitis B, and shorter waiting lists.[25] In 2000, Norwegian patients waited an average of 133 days for hip replacement, 63 days for cataract surgery, 160 days for a knee replacement, and 46 days for bypass surgery after being approved for treatment.[26] Short waits for cataract surgery produce better outcomes; prompt coronary artery bypass reduces mortality; and rapid hip replacement reduces disability and death.[27]

Britain has only one-fourth as many CT scanners as the US and one-third as many MRI scanners. The rate at which the British provide coronary bypass surgery or angioplasty to heart patients is only one-fourth of the US rate, and hip replacements are only two-thirds of the US rate. The rate for treating kidney failure (dialysis or transplant) is five times higher in the US for patients age 45 to 84 and nine times higher for patients 85 years of age or older.[28] Overall, nearly 1.8 million people are waiting to enter hospitals or for outpatient treatments at any given time.[29]

Canada is often said to deliver comparable care, produce comparable outcomes, and still spend less than the US.[30] However, the proportion of middle-aged Canadian women who have never had a mammogram is twice the US rate, and three times as many Canadian women have never had a pap smear. Fewer than 20% of Canadian men have ever been tested for prostate-specific antigen, compared with about 50% of US men. Only 10% of adult Canadians have ever had a colonoscopy, compared with 30% of US adults. These differences in screening may partly explain why the mortality rate in Canada is 25% higher for breast cancer, 18% higher for prostate cancer, and 13% higher for colorectal cancer.[31]

In view of such differences, it is not clear whether the U.S. spends too much on health care or other countries spend too little.

Is the Large Number of Uninsured in the US a Crisis?

The US is the only developed country in which a substantial subpopulation is nominally uninsured. Although this is said to be a crisis because the uninsured lack access to health care, the number of uninsured, and its consequences, are not clear.

The most widely used estimates of the number of US uninsured are from the US Census Bureau's Current Population Survey (CPS). It estimates that 47 million people were uninsured for the entire year in 2005.[32] The Survey of Income and Program Participation (SIPP), another Census Bureau survey, estimates about half that number. The Medical Expenditure Panel Survey (MEPS) and the National Health Interview Survey (NHIS) also generate lower estimates.[33] Many experts believe the CPS estimate is actually an estimate of the number of uninsured at a point-in-time. It is similar to the point-in-time estimates of SIPP (43 million in 2002), MEPS (48 million in 2004) and NHIS (42 million in 2004).[34]

Like unemployment, uninsurance is often transitory: 75% of uninsured spells last one year or less and 91% last two years or less.[35] Although the fraction of the population with health insurance rises and falls with the business cycle, since 1990 the CPS estimate has fluctuated between about 83 and 86% insured, despite an unprecedented influx of immigrants with uninsurance rates 2½ times that of the native-born population.[36] Guaranteed issue laws, state high risk pools, and retroactive Medicaid eligibility make it increasingly easy to obtain insurance after becoming ill.[37]

Of the 46 million nominally uninsured, about 12 million are eligible for such public programs as Medicaid and the State Children's Health Insurance Program (SCHIP).[38] They can usually enroll even at the time of treatment, arguably making them *de facto* insured. About 17 million of the uninsured are living in households with at least $50,000 annual income. More than half of those earn more than $75,000, suggesting that they are uninsured by choice.[39] Although 36% of people in families with incomes under 200% of the poverty level are uninsured, 44% have private coverage, and there are reasons to believe that expansion of private coverage is a better avenue to greater access to care than expansion of public programs.[40]

Does Lack of Health Insurance Cause Premature Death?

A number of studies suggest that the uninsured are more likely to suffer complications of preventable illnesses and more likely to die from them.[41] However, the case is much less solid than most studies in the medical literature have suggested. The consensus among economic studies is that "insurance has a relatively small effect on health."[42] Moreover, the uncertainties about who is uninsured, for how long, and for what reasons suggest that generalized claims about the nationwide impact of uninsurance should be greeted with skepticism.

An Institute of Medicine report in 2002 claimed that 18,000 deaths a year in the US could be attributable to a lack of health insurance.[43] The Urban Institute updated that number to 22,000 in 2006, and Families USA raised it to 26,260 in 2008.[44] However, these reports arrived at their results by extrapolating from an estimate made in a 15-year-old study, using 37-year-old data, and employing questionable methodology.[45] In fact, we do not know how much morbidity and mortality is attributable to lack of health insurance.

Once people see a provider, a RAND study suggests that insurance status has little effect on receipt of recommended care.[46] However, the uninsured and those on Medicaid may be more likely to delay seeking care.[47] An American Cancer Society study found that, relative to people with private insurance, the uninsured and Medicaid-insured were more likely to present with advanced-stage cancer at diagnosis.[48]

Many proposals for universal health care coverage envision enrolling more people in Medicaid, in SCHIP plans paying Medicaid rates, or in private plans paying Medicaid rates.[49] Such efforts encourage people to drop their private coverage. Cutler and Gruber estimate that every extra $1 spent on Medicaid reduces private health insurance by 50-75¢.[50] For SCHIP, the Congressional Budget Office projects a crowd-out rate of 25% to 50% and Gruber estimates it at 60%.[51] Unfortunately, this substitution may lead to worse health outcomes. Low Medicaid reimbursement is associated with lower quality care.[52] Perhaps because of nonprice barriers and low reimbursement for some types of care, being enrolled in Medicaid is only marginally better than being uninsured.[53]

Are Medical Bills Causing Bankruptcy?

A study claiming that more than half of all bankruptcies are caused by medical debt[54] is often cited, but the claim conflicts with four decades of economic research. The label "medical

bankruptcy" was applied if out-of-pocket medical bills exceeded $1,000, even though out-of-pocket expenses of the *average* US household were $2,182 in the year studied.[55] Recalculating the study's data, Dranove and Millenson conclude that only 17% of the sample "had medical expenditure bankruptcies."[56] Well-designed economic studies have found no statistical link between bankruptcies and health problems.[57] In fact, household consumption is largely unchanged even in the face of very large medical bills.[58]

Are Administrative Costs Higher for Private Insurance Than Public Insurance?

The Congressional Research Service has estimated the administrative costs of Medicare at 2% of the total program costs, compared to 10% for private insurance and 12% for HMOs. Some single-payer advocates have used this estimate as an argument for a universal Medicare program.[59] These estimates ignore hidden costs shifted to the providers of care, and the social costs of collecting taxes to fund Medicare. A Milliman & Robertson study estimates that, when these costs are included, Medicare and Medicaid spend two-thirds *more* on administration than private insurance spends on administration: 27 cents, compared to 16 cents, respectively, for every dollar of benefits.[60]

According to Himmelstein and Woolhandler, if the US adopted the Canadian system, the savings on lower administrative costs could pay for insuring the uninsured.[61] Their calculation includes the cost of private insurance premium collection (advertising, agents' fees, etc.), but ignores the cost of tax collection to pay for public insurance. Danzon estimates the deadweight cost of tax finance in Canada to be at least 17% of claims.[62] Using the most conservative estimate of the social cost of collecting taxes, Zycher calculates that the excess burden of a

universal Medicare program would be twice as high as the administrative costs of universal private coverage.[63]

Are Low-Income Families More Disadvantaged in the US System?

Aneurin Bevan, father of the British NHS, declared, "the essence of a satisfactory health service is that rich and poor are treated alike, that poverty is not a disability and wealth is not advantaged."[64] More than thirty years after the NHS founding an official task force found little evidence that the creation of the NHS had equalized health care access.[65] Another study fifty years after the NHS founding concluded that access had become more unequal in the years between the two studies.[66] Other scholarly studies have come to similar conclusions.[67]

In Canada, the wealthy and powerful have significantly greater access to medical specialists than less-well-connected poor.[68] High-profile patients enjoy more frequent services, shorter waiting times and greater choice of specialists.[69] Moreover, among the nonelderly white population, low-income Canadians are 22% more likely to be in poor health than their US counterparts.[70]

For OECD countries generally, among people with similar health conditions, "higher income people use the system more intensively and use more costly services than do lower income people."[71] It seems likely that the same personal characteristics that ensure success in a market economy also enhance success in bureaucratic systems.[72]

Can the Free Market Work in Health Care?

The US system is often portrayed as more market-based than the systems of other countries, but this portrayal may be more perception than reality. While 13 cents of every dollar is paid out-of-

pocket by US patients, the OECD average is 20 cents. [73] Throughout the developed world, third-party payers set fees and pay fees, perversely encouraging patients to overconsume and providers to manipulate reimbursement formulas to increase their incomes.[74] When third-party payment is not a factor, medical markets more closely resemble markets for other goods and services.[75]

In cosmetic surgery, virtually all payments are out-of-pocket and transparent package prices covering all services are the norm. Even though technological progress is frequently assumed to increase health care costs, the real price of cosmetic surgery has declined over the past 15 years, despite substantial technological progress and a six-fold increase in demand and.[76] In corrective vision surgery, out-of-pocket payments and package prices are the norm, and the real price has declined by 30% over the past decade.[77] Price transparency is absent in virtually every other kind of surgery.

Most walk-in clinics in drug stores and shopping malls began outside the third-party payment system. They have already achieved many of the goals included in most reform proposals: they post prices, keep electronic medical records (EMRs) and can prescribe electronically, taking advantage of error-reducing software.[78] Teladoc, which also developed outside the third-party payment system, offers telephone consultations. It maintains personal and portable EMRs, and its physicians prescribe electronically.[79]

Largely because so many drugs are purchased out-of-pocket, Rx.com began selling prescription drugs online, encouraging price competition in a national marketplace. Wal-Mart, a company in search of profits, has expanded its nationally advertised program of low cost generic drugs. Its efforts have spurred other retailers to engage in price competition as well.[80]

Outside the US borders, a vibrant, competitive international marketplace appears to be developing for all manner of medical services.[81] Package prices are customary, as are EMRs, and

information on quality. Moreover, many health centers abroad are affiliated with high-quality US facilities including the Cleveland Clinic, Mayo Foundation, Harvard Medical International, and Johns Hopkins Medicine International.[82]

CONCLUSION

Although national health insurance has considerable support within the medical profession, the degree to which patient empowerment, individual choice, competition, and market incentives are being consciously and successfully used to solve health care problems is far more extensive than is commonly realized. More than 10 million US families are managing some of their own health care dollars through Health Savings Accounts (HSAs) and Health Reimbursement Accounts.[83] More than half the states have Medicaid Cash & Counseling pilot programs underway, allowing the disabled to manage their own supportive care budgets. The satisfaction rate approaches 100%.[84] Internationally, Singapore has had a system of compulsory Medisave Accounts since 1984. China has initiated a pilot program based on the Singapore model.[85] In South Africa, HSA plans have captured more than half the private insurance market.[86] Switzerland, considered by many to have the most egalitarian health care system in the developed world, relies largely on private (although government-mandated) insurance.[87]

In some respects, support for government regulation of health care financing and delivery has been based on a narrow construal of selected data, while all too often ignoring contrary data. We have attempted to correct the record by discussing some specific gaps, and suggest that the discussion of US health care reform would benefit greatly from a careful examination of the current successes and future potential of market-based reforms.

ACKNOWLEDGEMENTS

Author Contributions:

Conception and design: Goodman, Gorman, Herrick, Sade

Acquisition of data: Goodman, Gorman, Herrick

Analysis and interpretation of data: Goodman, Gorman, Herrick, Sade

Drafting of the manuscript: Goodman, Gorman, Herrick

Critical revision of the manuscript for important intellectual content: Goodman, Gorman, Herrick, Sade

Statistical analysis: Goodman, Gorman, Herrick

Obtaining funding: N/A

Administrative, technical, or material support: Goodman, Gorman, Herrick, Sade

Supervision: Goodman

Financial Disclosures:

None

Funding/Support:

None

REFERENCES

[1] American College of Physicians, "Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn From Other Countries," Annals of Internal Medicine 148, no. 1 (2008): 55-75.

[2] "OECD Health Data: Specialists Outnumber GPs in Most OECD Countries," OECD Health Data 2007 (Paris: Organization for Economic Co-operation and Development, 2007) Chart 4: Health expenditure per capita, public and private, OECD countries, 2005. 2007, http://www.oecd.org/dataoecd/52/34/38976588.pdf (accessed 19 May 2008).

[3] S.S. Tan, WK Redekop and FFH Rutten, "Costs and Prices of Single Dental Fillings in Europe: a Micro-Costing Study," Health Economics 17, 1 Supplement (2008): S83-93.

[4] O. Tiemann, "Variations in Hospitalisation Costs for Acute Myocardial Infarction - a Comparison Across Europe," Health Economics 17, 1 Supplement (2008): S33-45.

[5] E. Orosz and D. Morgan, "SHA-based national health accounts in thirteen OECD countries: a comparative analysis," Health Working Papers no. 16 (Paris: Organization for Economic Co-operation and Development, 2004). "Note On General Comparability of Health Expenditure and Finance Data in OECD Health Data 2007," (Paris: Organization for Economic Co-operation and Development, 2007), http://www.ecosante.fr/ OCDEENG/411.html (accessed 19 May 2008). E. Orosz, "The OECD System of Health Accounts and the US National Health Account: Improving Connections Through Shared Experiences," (2005). Draft paper prepared for the conference on "Adapting National Health Expenditure Accounting to a Changing Health Care Environment" (Washington, D.C.: Centers for Medicare & Medicaid Services), http://www.cms.hhs.gov/NationalHealthExpendData/ downloads/confpaperorosz.pdf (accessed 19 May 2008); Jonas Schreyogg, etal., "Cross-Country Comparisons of Costs: The Use of Episode-Specific Transitive Purchasing Power Parities with Standardised Cost Categories," Health Economics 17, 1 Supplement (2008): S95-103.

[6] G.F. Anderson, B.K. Frogner and U.E. Reinhardt, "Health Spending in OECD Countries in 2004: an Update," Health Affairs 26, no. 5 (2007):1481-1489.

[7] Anderson, Frogner and Reinhardt, "Health spending in OECD countries in 2004: an Update;" Gerard F. Anderson, et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960–1998," Health Affairs 19, no. 3 (2000):150-157.

[8] S.A. Glied, "Health Care Financing, Efficiency, and Equity," NBER Working Paper 13881 (Cambridge, MA: National Bureau of Economic Research, 2008).

[9] R.G. Feachem, H.K Sekhri and L.K. White, "Getting More for their Dollar: a Comparison of the NHS with California's Kaiser Permanente," BMJ 324, no. 7330 (2002):135-143.

[10] D.C. Mendelssohn et al., "Haemodialysis Vascular Access Problems in Canada: Results from the Dialysis Outcomes and Practice Patterns Study (DOPPS II)," Nephrology Dialysis Transplantation 21, no. 3 (2006): 721-728.

[11] J. Hurst and L. Siciliani, "Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries," OECD Health Working Paper no. 6 (Paris: Organization for Economic Co-operation and Development, 2003).

[12] P.S. Hussey et al. "How Does the Quality of Care Compare in Five Countries?" Health Affairs 23, no. 3 (2004):89-99. C. Schoen and S.K.H How and S.C. Schoenbaum, National Scorecard on U.S. Health System Performance: Technical Report (New York: Commonwealth Fund, 2006). R.L. Lichtenstein, "The United States'

Health Care System: Problems and Solutions," Survey of Ophthalmology 39, no. 2 (1994):166-167. L. Champlin "Call for health system reform reaching grassroots level," (Leawood, KS: American Academy of Family Physicians, 8 November 2006), http://www.aafp.org/online/en/home/publications/news/news-now/health-care-reform/20061008grassroots.html (accessed 1 October 2008).

[13] H.C. Kung et al., "Deaths: Final Data for 2005," National Vital Statistics Report 56_10 (Hyattsville, MD: Centers for Disease Control and Prevention, 2008); Harvard University Initiative for Global Health, cited in M. Hitti, "Top States for Life Expectancy," WebMD Medical News, 2006, http://www.webmd.com/news/20060913 /top-states-for-life-expectancy (accessed 1 October 2008); C.J.L. Murray et al., "Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States," PLoS Medicine 3, no. 9 (2006): e260 doi:10.1371/journal.pmed.0030260.

[14] "Growing Disparities in Life Expectancy," Economic and Budget Issue Brief (Washington, DC: Congressional Budget Office, 2008).

[15] T.J. Mathews and M.F. MacDorman, "Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set," National Vital Statistics Report 55_14 (Hyattsville, MD: Centers for Disease Control and Prevention, 2007); V. Haynatzka et al., "Racial and Ethnic Disparities in Infant Mortality Rates --- 60 Largest U.S. Cities, 1995-1998," Morbidity and Mortality Weekly Report 51, no. 15 (2002): 329-332,343; T.J. Mathews and M.F. MacDorman, "Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set," National Vital Statistics Report 55_14 (Hyattsville, MD: Centers for Disease Control and Prevention 2007).

[16] E.M. Howell and B. Blondel, "International Infant Mortality Rates: Bias from Reporting Differences," American Journal of Public Health 84, no. 5 (1994):850-852; S. Sepkowitz "International Rankings of Infant Mortality and the United States Vital Statistics Natality Data Collecting System - Failure and Success," International Journal of Epidemiology 24, no. 3 (1995):583-588; M. Muller et al., "Liveborn and Stillborn Very Low Birthweight Infants in Switzerland: Comparison between Hospital Based Birth Registers And The National Birth Register," Swiss Medical Weekly 135, no. 29 (2005):433-439.

[17] N. Eberstadt, The Tyranny of Numbers: Mismeasurement and Misrule (Washington, DC: The AEI Press, 1995) 43-73.

[18] A. Verdecchia et al., "Recent Cancer Survival in Europe: a 2000–02 Period Analysis of EUROCARE-4 Data," Lancet Oncology 8, no. 9 (2007):784-796.

[19] Verdecchia et al., "Recent Cancer Survival in Europe: a 2000–02 Period Analysis of EUROCARE-4 Data."

[20] J.A. Staessen, T. Kuznetsova and K. Stolarz, "Hypertension Prevalence and Stroke Mortality Across Populations," Journal of the American Medical Association 289, no. 18 (2003):2420-2422. (Online edition, accessed 10 March 2006). K. Wolf-Maier et al., "Hypertension Prevalence and Blood Pressure Levels in 6 European Countries, Canada and the United States," Journal of the American Medical Association 289, no. 18 (2003):2420-2422.

[21] M.R. Joffres et al., "Distribution of Blood Pressure and Hypertension in Canada and the United States," American Journal of Hypertension 14, no. 1 (2001):1099-1105.

[22]G.R. Baker et al., "The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada," Canadian Medical Association Journal 170, no. 11 (2004):1678-1686.

[23] P. Kaul et al., "Long-Term Mortality of Patients with Acute Myocardial Infarction in the United States and Canada: Comparison of Patients Enrolled in Global Utilization of Streptokinase and t-PA for Occluded Coronary Arteries (GUSTO)-I," Circulation 110, no. 13 (2004):1754-1760, http://circ.ahajournals.org/cgi/content/full

/110/13/1754 (accessed 27 January 2006); J.L. Roleau et al., "A Comparison of Management Patterns After Acute Myocardial Infarction in Canada and the United States. The SAVE Investigators," New England Journal Medicine 328, no. 11 (1993): 779-784.

[24] M.A. McColl et al., "International Differences in Ageing and Spinal Cord Injury," Spinal Cord 40, no. 3 (2002):128-136.

[25] E. Kelley and J. Hurst, "Health Care Quality Indicators Project Initial Indicators Report," OECD Health Working Papers no. 22 (Paris: Organisation for Economic Co-operation and Development, 2006).

[26] L. Siciliani and J. Hurst, "Explaining Waiting Times Variations for Elective Surgery Across OECD Countries," OECD Health Working Papers no. 72003 (Paris: Organisation for Economic Co-operation and Development, 7 October 2003).

[27] W. Hodge et al., "The Consequences of Waiting for Cataract Surgery: A Systematic Review," Canadian Medical Association Journal 176, no. 9 (2007):1285-1290; B.G. Sobolev et al., "The Risk of Death Associated with Delayed Coronary Artery Bypass Surgery," BMC Health Services Research 6, no. 85 (2006), http://www.pubmedcentral. nih.gov/ picrender.fcgi? artid=1574305&blobtype=pdf (accessed 30 September 2008); E.M. Koomen et al., "Morbidity and Mortality in Patients Waiting for Coronary Artery Bypass Surgery," European Journal of Cardio-Thoracic Surgery 19, no. 3(2001):260-265; D.S. Garbuz et al., "Delays Worsen Quality of Life Outcome of Primary Total Hip Arthroplasty," Clinical Orthopaedics and Related Research 447 (2006):79-84. A.M. Davis et al., "Waiting for Hip Revision Surgery: the Impact on Patient Disability," Canadian Journal of Surgery 51, no. 2 (2008):92-96. V. Novack et al., "Does Delay in Surgery after Hip Fracture Lead to Worse Outcomes? A Multicenter Surgery," International Journal for Quality in Health Care 19, no. 3 (2007):170-176.

[28] H.J Aaron, Can We Say No? The Challenge of Rationing Health Care Health Care (Washington DC: Brookings Institution Press, 2005).

[29] NHS Wales Waiting Times: At End March 2008. Stats Wales 2008. SDR 58/2008. Patients Waiting (Edinburgh: National Services Scotland, 2008). NHS Inpatient and Outpatient Waiting Times Figures, 29 February 2008 and Revised Data for April 2006 – January 2008 (London: Department of Health, 2008).

[30] Physicians for a National Health program, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Journal of the American Medical Association 290, no. 3 (2003):798-805.

[31] J.E. O'Neill and D.M. O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S." NBER Working Paper 13429 (Cambridge, MA: National Bureau of Economic Research, 2007).

[32] C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," Current Population Reports no. 60-233 (Washington DC: U.S. Census Bureau, 2007).

[33] N. Chockley, H. Pirani and K. Kushner, "A Primer on the CPS Estimate of America's Uninsured," NIHCM Brief (Washington DC: National Institute for Health Care Management, 2006).

[34] Chockley, Pirani and Kushner, "A Primer on the CPS Estimate of America's Uninsured."

[35] R.J. Mills and S. Bhandari, "Health Insurance Coverage in the United States: 2002," Current Population Reports no. P60-223 (Washington DC: U.S. Census Bureau, 2003).

[36] C.H. Lee and S.M Stern, "Health Insurance Estimates from the U.S. Census Bureau: Background for a New Historical Series," (Washington DC: U.S. Census Bureau, 2007), http://www.census.gov/hhes/www/hlthins /usernote/revhlth_paper.pdf (accessed 23 May 2008). "National Health Interview Survey. Early release,"

(Hyattsville, MD: Centers for Disease Control and Prevention, March 2007) Figure 1.1 Percentage of persons of all ages without health insurance coverage at the time of interview: United States, 1997-September 2006, http://www.cdc.gov/nchs/data/nhis/earlyrelease/200703_01.pdf (accessed 23 May 2008); C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income Poverty, and Health Insurance Coverage in the United States: 2006," Current Population Reports no. P60-233 (Washington D.C: U.S. Census Bureau), p. 19.

[37] L. Wachenheim and H. Leida, The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets (Brookline, WI: Milliman, 2007).

[38] "The Uninsured in America," R30-03-014 (Chicago: BlueCross BlueShield Association, 2003).

[39] C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," Current Population Reports no. 60-235 (Washington DC: U.S. Census Bureau, 2008); H. Kuttner and M.S. Rutledge, "Higher Income And Uninsured: Common or Rare?" Health Affairs 26, no. 6 (2007): 1745–1752 (published online November 2007; 10.1377/hlthaff.26.6.1745).

[40] M.K. Bundorf and M.V. Pauly, "Is Health Insurance Affordable for the Uninsured?" Working Paper no. 9281 (Cambridge, MA: National Bureau of Economic Research, 2002); J.C. Goodman et al. Handbook on State Health Care Reform (Dallas: National Center for Policy Analysis, 2007).

[41] J. Hadley and J. Holahan, "How Much Medical Care do the Uninsured Use, and Who Pays for it?" Health Affairs 22 (2003):w3250-w3265. (published online 12 February 2003; 10.1377/hlthaff.w3.66). J. Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income," Medical Care Research and Review 60, no. 2 supplement (2003):3S-75S.

[42] R. Kronick, "Commentary—Sophisticated Methods but Implausible Results: How Much Does Health Insurance Improve Health?" Health Services Research 41, no. 2 (2006):452–460.

[43] Institute of Medicine, Care without Coverage: Too Little, Too Late (Washington, DC: National Academy Press, 2002).

[44] S. Dorn, Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality (Washington, DC: Urban Institute, 2008); "Dying for Coverage," (Washington, DC: Families USA, 2008), http://familiesusa.org/issues/uninsured/publications/dying-for-coverage.html (accessed 1 October 2008).

[45] P. Franks, C.M. Clancy and M.R. Gold, "Health Insurance and Mortality. Evidence from a National Cohort," Journal of the American Medical Association 270, no. 6 (1993):737-741; L. Gorman, "Dying for (Media) Coverage," Health Alert (Dallas: National Center for Policy Analysis, 2 May 2008), http://www.john-goodman-blog.com/dying-for-media-coverage/ (accessed 1 October 2008).

[46] S.M. Asch et al., "Who is at Greatest Risk for Receiving Poor-Quality Health Care?" New England Journal of Medicine 354, no. 11 (2007):1147-1156.

[47] J.S. Weissman at al., "Delayed Access to Health Care: Risk Factors, Reasons, and Consequences," Annals of Internal Medicine 114, no. 4 (1991):325-331.

[48] M.T. Halpern, E.M. Ward and A.L. Pavluck, "Association of Insurance Status And Ethnicity With Cancer Stage At Diagnosis For 12 Cancer Sites: A Retrospective Analysis," Lancet Oncology 9, no. 3 (2008):222-231.

[49] L. Dubay, C. Moylan and T.R. Oliver, "Advancing Toward Universal Coverage: Are States Able to take the Lead?" Journal of Health Care Law and Policy 7, no. 1 (2004):1-41. M.G. Bloche, "Health Care for All? New England Journal of Medicine 357, no. 12 (2007):1173-1175.

[50] D.M. Cutler and J. Gruber, "Does Public Insurance Crowd Out Private Insurance?" The Quarterly Journal of Economics 111, no. 2 (1996):391–430.

[51] N. Duchovny and L. Nelson, "The State Children's Health Insurance Program," CBO Pub no. 2970 (Washington, DC: Congressional Budget Office, 2007); J. Gruber and K. Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Heath Insurance?" Working Paper no. 12858 (Cambridge: National Bureau of Economic Research, 2007).

[52] J.D. Reschovsky and A.S. O'Malley, "Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?" Health Affairs 27, no. 3 (2008):w221-w231 (published online 22 April 2008; 10.1377/hlthaff.27.3.w222); J.E. Calvin et al., "Insurance Coverage and Care of Patients with non-ST Segment Elevation Acute Coronary Syndrome," Annals of Internal Medicine 145, no. 10 (2006):739-748.

[53] M.T. Halpern, E.M. Ward and A.L. Pavluck, "Association of Insurance Status And Ethnicity With Cancer Stage At Diagnosis For 12 Cancer Sites: A Retrospective Analysis," Lancet Oncology 9, no. 3 (2008):222-231. B.R. Asplin et al., "Insurance Status and Access to Urgent Ambulatory Care Follow-Up Appointments," Journal of the American Medical Association 294, no. 10 (2005):1248-1254.

[54] D.U. Himmelstein, etal., "MarketWatch: Illness and Injury as Contributors to Bankruptcy," Health Affairs 24 (2005): w63-w73 (published online 2 February 2005; 10.1377/hlthaff.w5.63).

[55] T.J. Zywicki, "An Economic Analysis of the Consumer Bankruptcy Crisis," Norwest University Law Review 99, no. 4 (2005):1463-1542.

[56] D. Dranove amd M.L. Millenson, "Medical Bankruptcy: Myth Versus Fact," Health Affairs 25, no. 2 (2005):w74-w83 (published online 28 February 2006; 10.1377/hlthaff.25.w74).

[57] S. Fay, E. Hurst and M. White, "The Household Bankruptcy Decision," American Economic Review 92, no. 3 (2002):706–718.

[58] H. Levy, "The Economic Consequences of Being Uninsured," ERIU Working Paper no. 12 (Ann Arbor, MI: University of Michigan, 2002), http://www.umich.edu/~eriu/pdf/wp12.pdf (accessed 1 October 2008).

[59] S. Woolhandler, T. Campbell and D.U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," New England Journal of Medicine 349, no. 8 (2003):768-775.

[60] M. Litow et al. "Rhetoric vs. Reality: Comparing Public and Private Administrative Costs," (Washington DC: Council for Affordable Health Insurance, 1994).

[61] S. Woolhandler and D.U. Himmelstein, "Paying for National Health Insurance—and not Getting It," Health Affairs 21, no. 4 (2002):88-98.

[62] P.M. Danzon, "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" Health Affairs 11, no. 1 (1992):21-43.

[63] B. Zycher, "Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured?" Medical Progress Report no. 5 (New York: Manhattan Institute for Policy Research, 2007).

[64] Economic Models Ltd. The British Health Care System (Chicago: American Medical Association, 1976).

[65] P. Townsend and N. Davidson, Inequities in Health Care, Black Report (Harmondsworth: Penguin, 1982).

[66] Independent Inquiries into Inequity and Health: The Acheson Report (London: Stationary Office, 1998).

[67] R. Mitchell and M. Shaw, Reducing Health Inequities in Britain (York, North Yorkshire: Joseph Roundtree Foundation, 2000).

[68] D.A. Alter et al., "Effects of Socioeconomic Status on Access to Invasive Cardiac Procedures and on Mortality after Acute Myocardial Infarction," New England Journal of Medicine 341, no. 18 (1999):1359-1367.

[69] S. Dunlop, P.C. Coyte and W. McIsaac, "Socio-Economic Status and the Utilisation of Physicians' Services: Results from the Canadian National Population Health Survey," Social Science & Medicine 51, no. 1 (2000):123-133.

[70] J.E. O'Neill and D.M O'Neill, "Health Status, Health Care and Inequality: Canada Vs. The U.S.," NBER Working Paper no. 13429 (Cambridge, MA: National Bureau of Economic Research, 2007).

[71] S.A. Glied, "Health Care Financing, Efficiency, and Equity," NBER Working Paper no. 13881 (Cambridge, MA: National Bureau of Economic Research, 2008).

[72] J.C. Goodman, G.L. Musgrave and D.M. Herrick, Lives at Risk: Single-Payer National Health Insurance around the World (Lanham, MD: Rowman & Littlefield, 2004), Chapter 21.

[73] C.L. Peterson and R. Burton, "U.S. Health Care Spending: Comparison with Other OECD Countries," (Washington DC: Congressional Research Service, 2007).

[74] J.C. Goodman, G.L. Musgrave and D.M. Herrick, Lives at Risk: Single-Payer National Health Insurance around the World (Lanham, MD: Rowman & Littlefield, 2004),

[75] J.C. Goodman and G.L. Musgrave, Patient Power: Solving America's Health Care Crisis, (Washington, D.C.: Cato Institute, 1992).

[76] D.M. Herrick, "Update 2006: Why Are Health Costs Rising?" Brief Analysis no. 572 (Dallas: National Center for Policy Analysis, 2006).

[77] H.T. Tu and J.H May, "Self-Pay Markets in Health Care: Consumer: Nirvana or Caveat Emptor?" Health Affairs 26, no. 2 (2007):w217-w226 (published online 6 February 2007; 10.1377/hlthaff.26.2.w217).

[78] K.J. Alexander, "Health Plans Embrace Retail Clinics," Managed Care 17, no.3 (2008):32-4, 43.

[79] D.M. Herrick, "Convenient Care and Telemedicine," Policy Report no. 305 (Dallas: National Center for Policy Analysis, 2007).

[80] "Use of Generic Prescription Drugs Prompts Decrease in Inflation," Kaiser Daily Health Policy Report (Menlo Park, CA: Henry J. Kaiser Family Foundation, 26 September 2007).

[81] M.D. Horowitz, J.A. Rosensweig and C.A. Jones, "Medical Tourism: Globalization of the Healthcare Marketplace," Medscape General Medicine 9, no. 4 (2007):33.

[82] D.M. Herrick, "Medical Tourism: Global Competition in Health Care," Policy Report no. 304 (Dallas: National Center for Policy Analysis, 2007).

[83] "January 2008 Census Shows 6.1 Million People Covered By HSA/High-Deductible Health Plans," (Washington DC: Americans Health Insurance Plans, 2006).

[84] B.C. Spillman, K.J. Black and B.A. Ormond, "Beyond Cash and Counseling: An Inventory of Individual Budget-based Community Long Term Care Programs for the Elderly," Issue Paper no. 7485 (Washington DC: Kaiser

Family Foundation, 2006). Also see Robert Wood Johnson Foundation, "Cash & Counseling," http://www.cashandcounseling.org/ (accessed 1 October 2008).

[85] N.C. Chia and A.K.C. Tsui, "Medical Savings Accounts in Singapore: How Much is Adequate?" Journal of Health Economics 24, no. 5 (2005): 855-875; "Health Care Trends. International Comparisons: Impact of HSAs on Costs and Utilization in Three Countries," Annual Report on Health Care (Milwaukee: Health Care Trends, 2005).

[86] "Health Care Trends. International Comparisons: Impact of HSAs on Costs and Utilization in Three Countries;" S. Matisonn, "Medical Savings Accounts in South Africa," Policy Report no. 234 (Dallas: National Center for Policy Analysis, June 2000).

[87] R.E. Leu and M. Schellhorn, "The Evolution of Income-Related Inequalities in Health Care Utilization in Switzerland over Time," IZA Discussion Paper no. 1316 (Bonn: Institute for the Study of Labor, 2004), http://ssrn.com/abstract=596941 (accessed 1 October 2008).

THE PHYSICIANS' FOUNDATION

The Physicians' Perspective: Medical Practice in 2008

Executive Summary

Healthcare is an issue of vital concern to most Americans, and has been in the public conversation nearly every day for years. At a time when both major political parties are calling for expanded healthcare access and a new Presidential administration and Congress are preparing to address the issue, one crucial viewpoint has been largely overlooked: that of the physicians themselves.

How do physicians across the country see the medical practice environment? How do they feel about the state of their profession, and that of the industry at large? What plans do they have for the future of their individual practices? Do they believe there are enough of them to handle an influx of more patients?

The Physicians' Foundation determined to answer these questions, and many more, through one of the largest and most comprehensive physician surveys ever conducted in the United States. Its goal was to give physicians a voice, so that their thoughts, ideas and concerns might be better understood by policy makers, employers, insurance companies and the public at large.

Through responses provided by approximately 12,000 physicians nationwide that included more than 800,000 data points – as well as through written comments by more than 4,000 physicians – the survey offers a unique and valuable insight into the practices and mindsets of today's doctors.

The results paint a grim picture that could have drastic implications for the nation's healthcare debate:

- **An overwhelming majority of physicians – 78% – believe there is a shortage of primary care doctors in the United States today.**
- **49% of physicians – more than 150,000 doctors nationwide – said that over the next three years they plan to reduce the number of patients they see or stop practicing entirely.**
- **94% said the time they devote to non-clinical paperwork in the last three years has increased, and 63% said that the same paperwork has caused them to spend less time per patient.**
- **82% of doctors said their practices would be "unsustainable" if proposed cuts to Medicare reimbursement were made.**
- **60% of doctors would not recommend medicine as a career to young people.**

Combine these statistics with recent studies showing that medical schools are graduating fewer and fewer students who will choose to become primary care doctors – and the future for both physicians and their patients seems uncertain at best.

In the years ahead, the condition of America's primary care doctors as a profession will greatly affect the viability of our nation's healthcare system. A positive and functional system of practices and doctors will ensure a motivated workforce as well as encourage a new generation of quality physicians, while widespread physician disincentive could jeopardize the quality of our medical workforce as well as the number of physicians available to see patients.

In the words of one physician who responded to the survey, "something has got to be done, and urgently, to assist physicians, especially primary care physicians" in order to maintain the viability of the medical profession and to ensure timely and effective access to the doctors on whom so many depend.

To read more about The Physicians' Foundation and view their complete survey, please visit www.physiciansfoundation.org.

ABOUT THE SURVEY

The Physicians' Perspective: Medical Practice in 2008 survey was conducted between May and July 2008 by physician search and consulting firm Merritt, Hawkins & Associates. It was mailed to 270,000 primary care doctors and more than 50,000 specialists – virtually every physician engaged in active medical practice in the United States today. The total number of responses received was 11,950. According to an independent analysis by Chad Autry PhD, Professor of Statistics at Texas Christian University, the margin of error for this survey is less than one percent.

ABOUT THE PHYSICIANS' FOUNDATION

The Physicians' Foundation seeks to advance the work of practicing physicians and to improve the quality of healthcare for all Americans. The Foundation is unique in its commitment to working with physicians nationwide to create a more efficient and equitable healthcare system. The Physicians' Foundation pursues its mission through a variety of activities including grantmaking and research. Since 2005, the Foundation has awarded more than $22 million in multi-year grants. The Physicians' Foundation was founded in 2003 through settlement of a class-action lawsuit between physicians, medical societies, and third-party payors. Additional information about The Physicians' Foundation is available online at www.physiciansfoundation.org.