

# Health Affairs

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At the Intersection of Health, Health Care and  
Policy

Cite this article as:

M L Barer, R G Evans, M Holt and J I Morrison  
It ain't necessarily so: the cost implications of  
health care reform  
*Health Affairs* 13, no.4 (1994):88-99  
doi: 10.1377/hlthaff.13.4.88

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# Commentary

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## It Ain't Necessarily So: The Cost Implications Of Health Care Reform

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by Morris L. Barer, Robert G. Evans, Matthew Holt, and  
J. Ian Morrison

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There is widespread recognition that U.S. health care costs are out of line with those of the rest of the world and acceptance in most quarters that this is hurting someone—if not America's competitive position, then at least the U.S. workers who are having to give up wages (and probably a few jobs).<sup>1</sup> In all other countries in the Organization for Economic Cooperation and Development (OECD), there appears to be an understanding that health care systems are not self-limiting. Like a neoplasm, they are quite content to feed on their hosts, oblivious to the fact that the more they gorge themselves, the less able their host “organisms” are to support them.

On the surface, there appears to be a determination to do something about this situation. In a recent poll, federal legislators ranked health care cost control as priority number one, ahead of universal coverage.<sup>2</sup> Yet as the debate has heated up, cost control has taken a back seat to the search for formulae to support the funding of reform. The operative assumption is that extending coverage will require additional funds. How to get to (only) 17 percent of gross domestic product (GDP) by the turn of the century, rather than whether such a level is reasonable, necessary, or inevitable, has become the issue of the day.

The thesis of this paper is that “it ain't necessarily so,” that the automatic presumption of cost expansion from extending coverage to all is rooted in a particular set of assumptions about how health care has to look in the United States after reform, and about the nature of financial flows and their links to real services in health care markets.

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## So What Is Really Going On?

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If a key legislative priority is cost control, why is so much of the debate about new sources of funding? It may be that in the minds of those close to the reform process, health care cost control means holding health care cost increases to levels lower than they probably would have been in the absence of any national health care reform initiative. Conveniently, this is an objective that cannot be evaluated—we never get to see the “control” for the “experiment.”

Alternatively, it may be that the cost of getting the “slope” down is that the “intercept” must first drift up; the “slippage” from 14 percent to 17-18 percent is simply inevitable cost expansion prior to the full implementation of reform. But this sounds too much like the well-worn arguments of every snake oil salesperson (or health care advocate) in history: It will cost a little now, but you won’t believe the savings later.

There is, of course, another possibility. It may be that health care cost control really is not very important to Americans after all.<sup>3</sup> The American public appears to be of two minds. On the one hand, they thrive on the romance of the opportunities this country offers to “make it big” (in health care as elsewhere), not realizing that personal fortunes made by the entrepreneurs in investor-owned hospitals and health maintenance organizations (HMOs) come out of their pockets. They continue to live in a world of positive-sum games, where there is yet another “open frontier” over the next hill and where, therefore, there is no particular reason to want to control health care costs. Furthermore, they are reasonably satisfied with the “health care services they and their family receive.”<sup>4</sup> Any serious attempt to control costs would affect those services and relationships (or so they have been convinced).

On the other hand, as Daniel Yankelovich and John Immerwahr have pointed out, Americans are uncomfortable with rising health care costs, which they attribute to “greed, high salaries, corruption, waste,” and so on.<sup>5</sup> So they want cost control, but they haven’t quite figured out that cost control means controlling those very opportunities that they hold so dear.

Whatever logic the legislators use, once one buys into the “flexible” notion of 17 percent of GDP as health care cost control, then any number of wonderful things are possible, and a number of more unpleasant things are avoidable. Attention can then focus not on mechanisms for actually stopping the flow of helium into the balloon, but instead on new sources of helium and the task of selling the additional costs to the public. The key to this sale is the notion that extending coverage to the uninsured will inevitably require additional funding; that is, costs will have to increase before they can be controlled.

This has become so taken for granted that it barely merits discussion. The most important issue for the Clinton administration is universal coverage. Virtually all other aspects of the administration's plan appear to be on the bargaining table, marginalized by the uneasiness of the middle class about health care security.<sup>6</sup> Job number one is to find mechanisms for providing secure and portable coverage to that nervous middle class-portable across geography, employment, and the life cycle.

But there is no politically practical way to do this without, *inter alia*, providing coverage for the thirty-seven million uninsured (15 percent of the population) and upgrading benefits for those with inadequate coverage. That is where those alleged new costs come in. Calculations on the back of an envelope very quickly yield a figure of about \$70 billion (thirty-seven million times a \$1,900 average per person premium). But of course this revenue-side fixation is not helpful; indeed, it is quite misleading, for a variety of reasons most clearly exposed through the use of a simple accounting identity.

**My pain, your gain, or every dollar of expenditure is a dollar of income.** However it is raised, the total amount of revenue provided for health care is linked to two other important aggregates. It must always equal the total cost of the care received and provided, and it must equal the total of all of the incomes earned from the provision of care by those who directly or indirectly participate in-supply reimbursed resources for-its provision: total revenue equals total expenditures equals total incomes. Each dollar spent on health care must simultaneously have come from someone, and have been paid to someone, for some thing. More precisely,  $T + CQ + R = PQ = WZ$ , where T is tax revenue; C is out-of-pocket payments of all sorts on services actually consumed, Q; R is revenue raised through insurance premiums; P is prices of health care goods and services; W is wages/ incomes of health care workers and suppliers; and Z is the various types of such income recipients.<sup>7</sup>

The relationship does not, of course, hold for each person in the country. Most people will contribute either much more or much less on the revenue side than the cost of the services they use; on the other side of the equation, the amount that people earn from providing health care will typically be either much more, or much less, than they contribute to pay for it. But in aggregate, summed over all of the individuals making up society as a whole, the relationship must hold-it is an identity.

This means that if extending coverage to all really does require new sources of revenue, then there also will be changes in the mix of prices and/or quantities of health care services-total health care spending must rise-and there must be changes in the mix and levels of incomes-total incomes derived from health care must increase.

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## The Need For New Revenue Revisited

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But must extending coverage to the entire population mean an increase in costs, and therefore a need to search for new sources of revenue? There are at least two good reasons to question this notion.

**International experience.** That the U.S. health care system costs more and covers fewer than health care systems anywhere else in the developed world is well known. All other OECD countries, for example, provide universal health care coverage at a fraction of the U.S. cost.<sup>8</sup> Relative to the rest of the “relevant world,” the United States over the past two decades has moved toward covering less of its population.<sup>9</sup> The great irony is that over this same period, it has pulled away from the pack in its cost experience.

This is perhaps the strongest *prima facie* evidence that extending coverage in the United States need not necessarily mean increasing costs. It depends critically on what else one is prepared to do (and how one proposes to do it). Some may argue that where you end up depends critically on the point from which you start and that the United States is at a serious disadvantage in that respect, because its costs are already so much higher.

But this overlooks at least three things. First, Canada and the United States were, for all practical purposes, at the same starting gate in 1971; thus, where you end up does not depend on where you start. Second, even if it did, it does not explain the move from 14 percent to 17 percent or 20 percent of GDP predicted for the United States. Third, one does not “end up” anywhere. The process has no beginning and no end. Where one finds oneself in any given year depends more fundamentally on which way one wants to go and how one wishes to get there.

So how do all of those other countries provide coverage for all while holding costs to levels well below those found in the United States? The basic common thread is some form of monopsony control over health care budgets, or at least the most significant segments of them. In our identity terms, collective and binding decisions are made about how large  $P \times Q$  is going to be, through controlling the available revenue. This, in turn, implies (as the identity shows) control over total incomes (although not necessarily the numbers of income recipients or the levels of individual incomes). Each country has adopted its own unique type of control over the number and mix of income recipients and over the levels of expenditures ( $P \times Q$ ) in particular sectors.<sup>10</sup> But the common element is that control. While competition and clinical oversight (in the form of utilization management or review) may be permitted or even encouraged, nowhere but in the United States does anyone propose to rely on these mechanisms to actually control overall costs.

One might (and some do) argue that the United States is different from

other countries in some fundamental and important ways.<sup>11</sup> And, indeed, it has treated with appropriate skepticism any suggestions that a system that seems to work in another country should simply be imported. But “it couldn’t work here” as a response to something that appears to work in virtually all other countries appears unnecessarily xenophobic.

**Macro-assumptions and micro-use estimates.** One need not rely on the lessons of others to question the assumption that extending coverage must increase costs. The basic presumption is that extending coverage to those without it will increase use of services by some considerable amount and that this will result in increased overall expenditures.<sup>12</sup> Yet those now without coverage generally receive care when they really need it. In fact, they end up (on average) being sicker than those with coverage by the time they make it into the system, so that their health care needs, per episode of illness, are greater than they would have been if they had had coverage.<sup>13</sup> The argument hinges critically on assumptions that those without insurance will, when they have it, adopt the care-seeking patterns of those with insurance, that this will increase their overall use of health care services, and that nothing much else will happen.

While the flow of funds may not be as obvious as supermarket shopping, underneath the current care of the uninsured, funds do flow. Care is still provided, people still get paid to provide it, and revenue is raised and distributed so that it can be provided. It is already in all three segments of the identity, although the prices of health care goods and services (the Ps) may not be explicit. Public institutions receive funding through tax expenditures and other forms of public and private subsidy; they pay staff and purchase the supplies and services that make up the provision of care for the uninsured. Where providers offer free care to those unable to pay, the rest of their patients cross-subsidize this care through higher prices. And so on.

But assume that the services used (the Qs) will, in fact, increase for the uninsured once they have coverage. Even taking the recent Congressional Budget Office (CBO) estimate that use by the uninsured may increase as much as 60 percent if they become insured, we are talking about 15 percent of the population, so that the aggregate impact would be under 10 percent. A 10 percent increase in costs would be a large number, although relative to recent rates of expansion in U.S. health care costs, not that big. More importantly, this estimate, too, is biased upward because it oversimplifies the world in a number of fundamental and now well understood ways.

Crude comparisons between insured and uninsured populations on which such estimates are often based generally overstate the probable increase in use by the uninsured if they were to become insured. More fundamentally, even marginal estimates (which attempt to adjust for everything but insurance status) are based in one way or another on partial

analyses. That is, they are generated using utilization observations based on situations in which only some of the patient and provider populations are involved. It is a simple (and common) fallacy of composition to generalize from such situations to population estimates.<sup>14</sup>

In particular, such analyses commonly adopt the economist's best friend, *ceteris paribus*-all else unchanged. But in the real world "all else" never sits and watches. It gets involved. International experience has shown clearly that major changes in funding mechanisms or sources lead to changes in the Ps and Qs that cannot be modeled in this manner. Any number of things could transpire or be brought about. Managed competition (if that is what we end up with) could push the implicit (and explicit) Ps down so that, despite increased Qs, total expenditures remain unchanged (or even, heaven forbid, fall). Some of the Zs (income recipients) could disappear entirely (resulting in the reduction or elimination of other Ps and Qs), or some of the wage levels or product prices could fall, again leaving  $P \times Q$  at or below existing levels.<sup>15</sup> Or, as was the experience in Canada when universal coverage was introduced, there could be a redistribution of the Qs, so that those who do not have coverage increase their use of services, while those with coverage decrease their use of services.<sup>16</sup>

This is more than simply idle algebraic manipulation. There is now a vast, growing, and largely U.S.-based literature demonstrating not only that huge small-area variations exist in rates of service, but also that significant shares of the Qs are inappropriate for a wide array of clinical services; there is lots of room, in practical terms, to reduce utilization.<sup>17</sup> Similarly, David Himmelstein and Steffie Woolhandler, in particular, have noted the excess burden placed on the U.S. health care system by excessive administrative costs (relative to other systems)—unnecessary Zs and, therefore, more unnecessary Qs, but of a different type.<sup>18</sup> Research on comparative hospital costs and medical prices in Canada and the United States has revealed that there is room to move Ps (and therefore Ws [wages of providers and suppliers]) down in the United States without affecting the health status of patients or the supply of health care workers (particularly physicians).<sup>19</sup>

The most credible estimates emerging from the microanalyses suggest that providing coverage for the uninsured would increase costs by well under 5 percent, perhaps by as little as 2 percent. But if it is 2 percent, why could it not be 0 percent, or even -2 percent? The answer is that it could. The technically sophisticated and careful microanalytic effort is in large part waste motion. It is very difficult to develop dynamic models that will predict with any accuracy the population-level interactive effects of major system financing or structural changes that involve moving into uncharted territory (because the estimation process depends for its observations on what has already been observed in small slices of the nation's population).



Perhaps even more important, the international experience reminds us that the actual numbers could be pretty much whatever the reform architects wish them to be. There is an assumed exogeneity in this modeling and estimation process that parallels the U.S. approach to health care reform, whereas elsewhere the process appears to be more one of setting goals and then developing the reform architecture to meet them.

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### The Possible Versus The Plausible

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Why, then, did the Clinton administration put forth a plan that will not contain health care costs and that seems quite explicit about that? We see a number of reasons.

**Income recipients are noisy, and powerful.** True control of costs (rather than simply slowing their rate of growth as a percentage of GDP) requires some combination of controlled prices and quantities, on the one hand, and controlled incomes/wages and income recipients, on the other. There are no other ways to control costs in the health care sector, or at least none that have ever been demonstrated to be effective across entire populations (that is, at the level where the possibilities for cost shifting dry UP).<sup>20</sup> But because there are so many players and payers in the United States, cost control has always been possible by cost shifting, and everyone has been doing it or at least giving it a good try. The only place cost shifting is never possible is in the aggregate expenditure (including the percentage of GDP) statistics—the end of the frontier, so to speak. But of course the percentage of GDP is no one's bottom line, so why worry about it?

Thus, the reasons that this country is not likely to see health care cost control any time soon are all plain to see in the expenditure/income identity. One person's costs are another person's income, and when the costs are diffuse and the incomes concentrated (in algebraic terms, most of the Zs incur some health care costs; few of them earn health care incomes), those concentrated incomes provide powerful incentives to undermine any threat to the continued flow of money.<sup>21</sup> If one is truly interested in improved efficiency and effectiveness, someone's ox has to get gored. Curiously, the various analyses of the effects of reform have been largely silent on the issue of health care incomes.

This dichotomy between diffuse costs and concentrated incomes is reflected most importantly in the use and manipulation of the media. Not only are the key income recipients (or their representatives) able and willing to invest huge sums in getting their message out effectively, but the alleged clinical effects of cost control make much sexier news coverage than the opportunity costs of throwing ever more money at ever-declining health returns.<sup>22</sup> That elusive cure for cancer is also just over the next hill,

if only. . . . Meanwhile, cancer rates among baby boomers appear to be higher than among their grandparents, and \$25 billion spent in the war against cancer has left “victory” nowhere in sight.<sup>23</sup> So the public (which is, in the end, paying for the health care and the media coverage) gets two sets of messages reinforcing the notion that they should pay now, and they should pay more later.

But the special-interest groups have help. Debate about how to pay is, in large measure, a debate about who shall pay. Those fortunate enough to be healthy, or wealthy, or both, accurately perceive their own strong interest in retaining the current patchwork private form of financing. It is far more regressive than any shift toward an income tax-based system would be.<sup>24</sup>

**Control of capital is a long-term proposition.** Cost control requires more than simply the control of current incomes. It requires control of future expectations of incomes or returns on investment. These come in three forms: human, intellectual, and physical capital. Each form has a long half-life; once created, it will expect to draw some of those health care revenues for many years. Whether they be physicians or other health care workers, workers or shareholders in pharmaceutical or device manufacturing firms, or workers or shareholders in architectural and construction companies, the creation of health care capital leaves them better off.<sup>25</sup>

There is virtually nothing in the administration’s reform package that takes up this issue of capital creation as the creation of future income expectations. One cannot simply attempt to impose cost control without making compensatory adjustments on the training and investment sides, unless one really is interested in presiding over a broad income-reduction policy (which might not, of course, be such a bad thing).

But even if the will were there, adjustments on the capital side take time to play out. For example, if one were to decide that the total number of physicians being trained should be reduced, while the policy could be implemented today, its first effects would be at least five years away. Also, the fragmented control of the capital side of the health care market makes the implementation of any such policies exceedingly difficult.<sup>26</sup>

Furthermore, one of the key arguments against cost control is that it will stifle the particular form of physical capital born of technological innovation: If high-tech companies see fewer opportunities to peddle wares in the health care sector, they will simply reduce the research and development (R&D) going into that area, and this would be a bad thing. This is too simplistic a view, for at least three reasons.

First, if a reformed health care environment places greater importance on the demonstrated effectiveness—indeed, cost-effectiveness—of new technology, and if this has the effect of reducing the flow of products, perhaps that is not so bad. It may reduce jobs and eliminate some incomes in one

sector, but that must be seen not just as a cost but also as an opportunity to create economic activity where there is greater social benefit.

Second, a new cost-conscious environment ought to spawn technological innovation of a different sort. Until now, in a procedure-driven revenue environment, the emphasis has been on new technology as a source of revenue rather than as an added cost. But with the shift toward capitated environments, and therefore from a revenue-center mentality to a cost-center mentality, different criteria are going to be applied. Those different criteria are likely to be reflected in where the technological innovation sector puts its energy—there will be a premium on demonstrated health-enhancing and cost-reducing technologies. Here there really are new frontiers waiting to be explored, and exploited. Innovation in health care system organization, information systems, and managerial technologies, in addition to effective breakthrough clinical technologies, will continue to be rewarded. The keys, however, will be improving health outcomes and/or reducing costs, not increasing revenues.

Third, in this area there are, in fact, many untapped geographical frontiers. There are endless export markets for shiny new health care technology—endless opportunities to create cost problems in other health care systems. This is particularly pernicious when it leads poor, developing countries to squander their scarce health care dollars on expensive toys. But in an increasingly constrained home market, look for more of it.

**The illusion of more frontiers.** A third reason that cost control does not play prominently in the current reform effort is that it is still, somehow, seen as not all that necessary. The recent Republican “What Crisis?” ploy is simply one highly visible example of a more deep-seated belief that continued increases in health care costs are not really such a bad thing.<sup>27</sup> And, indeed, since costs are also incomes, and since jobs and incomes are good things, why not continue to funnel resources into health care jobs?

The problem with this line of reasoning is that there really are no more frontiers. There is only cost shifting. The costs of more health care are counted in the jobs and wealth-creating potential given up elsewhere. They are counted in less funding for education and other forms of social support, in lower wages, and, ultimately (and paradoxical as it may seem), in lower levels of health status.<sup>28</sup>

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## A Final Word

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And so, while “it ain’t necessarily so,” it seems likely that the price of security will be higher costs. The “tragedy of the commons” continues to play out, despite the fact that the way out is really not all that hard to see. Therein lies a dilemma for Bill and Hillary Clinton and their well-meaning

staffs. Their constituents are very dissatisfied with their current health care system. Americans have not demonstrated that they are much interested in creating a better system if it means at the same time having to control costs (or, rather, they have been convinced that any number of terrible things will happen if they try). They are not much interested in increasing costs (unless, of course, someone else pays).

So what do Americans want? it appears to us that they do not really know, or, rather, that they are being kept so confused by the competing claims, counterclaims, and rhetoric, they have no hope of being able to sort this one out. They are not alone. Many of their elected officials seem equally confused. Unfortunately, a system for “tithing” lies and self-interested half-truths has not yet been devised; since lies and half-truths are “underpriced,” they will continue to proliferate, and so will the confusion.

There are good and obvious reasons for keeping the confusion levels high. But they have nothing to do with sensible health care reform. And while revenue-neutral health care reform is possible in any country—even the United States—that game cannot be won if the special interests continue to control the distance between the goalposts.

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*This research was funded in part by The Robert Wood Johnson Foundation through Grant no. 18837.*

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## NOTES

1. U.E. Reinhardt, “Health Care Spending and American Competitiveness,” *Health Affairs* (Winter 1989): 5-21.
2. Louis Harris and Associates, “Federal Legislator Survey” (Unpublished proprietary document, February 1993).
3. A survey in 1978 indicated that the American public both seriously overestimated the share of gross national product (GNP) going to health care and felt that an appropriate level would be in the 16-20 percent range. J. Gabel, H. Cohen, and S. Fink, “Americans’ Views on Health Care: Foolish Inconsistencies?” *Health Affairs* (Spring 1989): 103-118. In contrast, a recent informal poll of physicians suggested a better grasp on the share of national income consumed by health care but little sense of the actual dollars involved. G.A. Diamond, “DOctors’ Estimates of U.S. Health Care Spending,” Letter to the Editor, *The New England Journal of Medicine* 328 (1993): 1202.
4. R.J. Blendon et al., “Satisfaction with Health Systems in Ten Nations,” *Health Affairs* (Summer 1990): 185-192.
5. D. Yankelovich and J. Immerwahr, “A Perception Gap,” *Health Management Quarterly* 13, no. 3 (1991): 11-14.
6. See J.N. Edwards, R.J. Blendon, and R. Leitman, “The Worried Middle Class,” in *Containing Health Care Costs in an Era of Universal Coverage*, ed. R.J. Blendon and T.S. Hyams (New York: Faulkner and Gray, 1992), 61-81.
7. The more complete algebraic development can be found in R.G. Evans, M.L. Barer, and G.L. Stoddart, “Charging Peter to Pay Paul: Accounting for the Financial Effects of User Charges” (Toronto: Ontario Premier’s Council on Health, Well-Being, and Social Justice, 1994).

8. G.J. Schieber, J.P. Poullier, and L. Greenwald, "U.S. Health Expenditure Performance: An International Comparison and Data Update," *Health Care Financing Review* (Winter 1992): 1-88.
9. D. Walden, G. Wilensky, and J. Kasper, *Changes in Health Insurance Status: Full Year and Part Year Coverage*, Pub. no. (PHS)85-3377 (Washington: Department of Health and Human Services, July 1985); and J. Foley, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1991 Current Population Survey*, EBRI Issue Brief 123 (Washington: Employee Benefit Research Institute, February 1992).
10. B. Abel-Smith, "Cost Containment and New Priorities in the European Community," *The Milbank Quarterly* 70, no. 3 (1992): 393-416.
11. See H. Taylor and U.E. Reinhardt, "Does the System Fit?" *Health Management Quarterly* 13, no. 3 (1991): 2-10.
12. See W. Manning et al., "Health Insurance and the Demand for Medical Care," *American Economic Review* 77, no. 3 (1987): 251-277; S. Long and J. Rodgers, "The Effects of Being Uninsured on Health Care Service Use," Survey of Income and Program Participation (SIPP) Working Paper no. 9012 (Washington: U.S. Bureau of the Census, 1990); B.C. Spillman, "The Impact of Being Uninsured on Utilization of Basic Health Care Services," *Inquiry* (Winter 1992): 457-466; J.F. Sheils, L.S. Lewin, and R.A. Haught, "Potential Public Expenditures under Managed Competition," *Health Affairs* (Supplement 1993): 229-242; and Congressional Budget Office, *Behavioral Assumptions for Estimating the Effects of Health Care Proposals*, CBO Staff Memorandum (Washington: CBO, 1993).
13. U.S. Congress, Office of Technology Assessment, *Does Health Insurance Make a Difference?* Pub. no. OTA-BP-H-99 (Washington: U.S. Government Printing Office, 1992).
14. To make the point, consider a hypothetical situation in which providers are fully employed, and in which use of providers by those without insurance is 65 percent that of those with insurance. Assume further that the uninsured represent 15 percent of this population. To conclude from this that extending coverage to those without insurance would increase aggregate use of services by 8 percent [ $54 \text{ percent} (1/0.65) \times 15 \text{ percent}$ ], neglects to take into account the inconvenient fact that the capacity to provide care is already fully occupied.
15. For example, were much of the pure waste motion (in terms of impact on health status) associated with insurance underwriting, risk rating, and all that eliminated, in our algebraic terms this would amount to the elimination of a bunch of Zs and Qs to match. Not all "health care services" involve the laying of hands or instruments on patients; this is particularly true in the United States.
16. See P.E. Enterline et al., "Effects of Free Medical Care on Medical Practice—The Quebec Experience," *The New England Journal of Medicine* 288 (1973): 1152-1155; and P.E. Enterline et al., "The Distribution of Medical Services Before and After 'Free' Medical Care—The Quebec Experience," *The New England Journal of Medicine* 289 (1973): 1174-1178.
17. For a recent synthesis of much of this literature, see N.P. Roos and L.L. ROOS, "Small Area Variations, Practice Style, and Quality of Care," in *Why Are Some People Healthy and Others Not?* ed. R.G. Evans, M.L. Barer, and T.R. Marmor (Hawthorne, N.Y.: Aldine de Gruyter, 1994).
18. D.U. Himmelstein and S. Woolhandler, "Cost Without Benefit: Administrative Waste in U.S. Health Care," *The New England Journal of Medicine* 314 (1986): 441-445; and S. Woolhandler and D.U. Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *The New England Journal of Medicine* 324 (1986): 1253-1258.
19. See, for example, V.R. Fuchs and J.S. Hahn, "How Does Canada Do It? A Comparison

- of Expenditures for Physicians' Services in the United States and Canada," *The New England Journal of Medicine* 323 (1990): 884-890; and D.A. Redelmeier and V.R. Fuchs, "Hospital Expenditures in the United States and Canada," *The New England Journal of Medicine* 328 (1993): 772-778. Recent research by staff of The Urban Institute and their colleagues suggests that Canadian fees are about 45 percent of American private (non-Medicare/Medicaid) fees. W.P. Welch, S.J. Katz, and S. Zuckerman, "Physician Fee Levels: Medicare versus Canada," and M.E. Miller, S. Zuckerman, and M. Gates, "How Do Medicare Physician Fees Compare with Private Payers?" *Health Care Financing Review* (Spring 1993): 41-54 and 25-39. Yet physicians in Canada are still among the highest-paid professionals, and there is no mass migration out of the country.
20. "Pure" managed competition might do the trick. But after twenty years of advocacy, the United States has yet to see 'pure' managed competition. The claim must still be taken on faith. There is not as yet evidence from anywhere else in the world to support the claim, and there are doubts expressed even in the United States. See, for example, T. Rice, E.R. Brown, and R. Wyn, "Holes in the Jackson Hole Approach to Health Care Reform," *Journal of the American Medical Association* 270, no. 11 (1993): 1357-1362; J. Fielding and T. Rice, "Can Managed Competition Solve the Problems of Market Failure?" *Health Affairs* (Supplement 1993): 216-228; and Congressional Budget Office, *The Effects of Managed Care on Use and Costs of Health Services*, CBO Staff Memorandum (Washington: CBO, 1992). The latter concludes that the plan-specific evidence on cost and use reduction for group- and staff-model HMOs does not necessarily yield lower systemwide costs.
  21. See T.R. Marmor, D.A. Wittman, and T.C. Heagy, "The Politics of Medical Inflation," *Journal of Health Politics, Policy and Law* 1 (1976): 69-84; and R.G. Evans, "Life and Death, Money and Power: The Politics of Health Care Finance," in *Health Politics and Policy*, ed. T.J. Litman and L.S. Robins (Albany, N.Y.: Delmar, 1990). In health care as elsewhere, those incomes are becoming more concentrated. See P.R. Krugman, "The Rich, the Right, and the Facts: Deconstructing the Income Distribution Debate," *The American Prospect* (Fall 1992): 19-31; and A.B. Fisher, "The New Debate over the Very Rich," *Fortune* (29 June 1992): 42-54.
  22. See "Health-Care Hucksters: What Their Ads Say-And Don't Say," *Consumer Reports* (February 1994): 116-117.
  23. See T. Beardsley, "A War Not Won," *Scientific American* 270, no. 1 (1994): 130-138.
  24. In particular, the more one relies on out-of-pocket payments to finance care, the greater the relative burden on those with lower incomes (who are also, of course, disproportionately those in greater need of care); See E. Rasell, J. Bernstein, and K. Tang, "The Impact of Health Care Financing on Family Budgets," *Economic Policy Institute Briefing Paper* (Washington: EPI, April 1993).
  25. On this point, see M.L. Barer and R.G. Evans, "The Meeting of the Twain: Managing Health Care Capital, Capacity, and Costs in Canada," in *Technology and Health Care in an Era of Limits*, ed. A. Gelijns (Washington: National Academy Press, 1992).
  26. See F. Mullan, "Missing: A National Medical Manpower Policy," *The Milbank Quarterly* 70, no. 2 (1992): 381-386.
  27. Elected Republicans are not alone in this peculiar belief. See M. Pauly, "U.S. Health Care Costs: The Untold True Story," *Health Affairs* (Fall 1993): 152-159.
  28. See R.G. Evans and G.L. Stoddart, "Producing Health, Consuming Health Care," *Social Science and Medicine* 31, no. 12 (1990): 1347-1363; and Evans et al., *Why Are Some People Healthy and Others Not!*