

INTRODUCTION TO Public Health

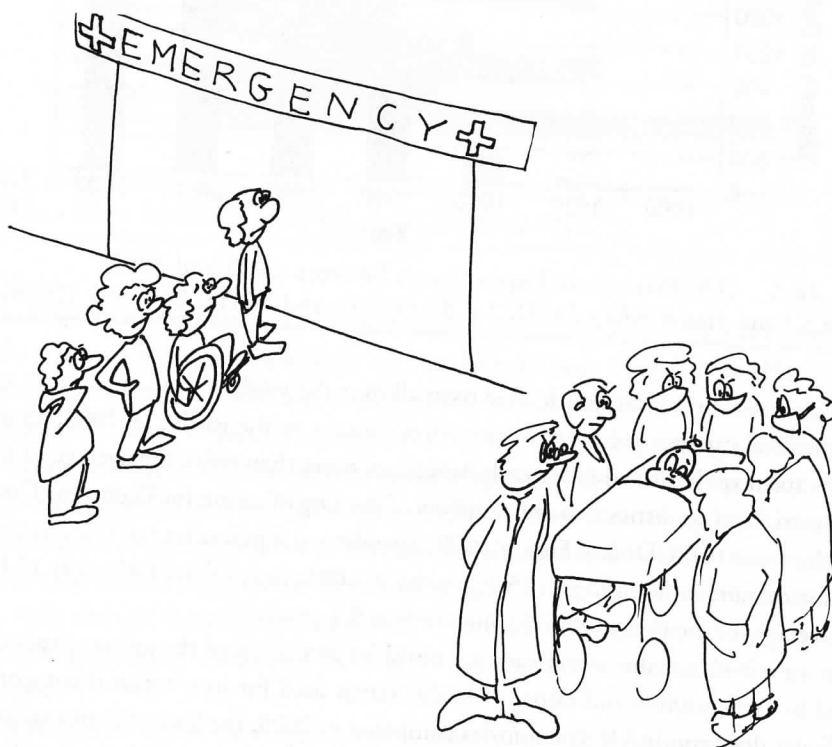
Third Edition



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CHAPTER 26

Why the U.S. Medical System Needs Reform



Inequalities in Access

It was obvious almost as soon as Medicare and Medicaid were enacted that the U.S. healthcare system still had problems. Medical costs in the United States, which had been rising more rapidly than general inflation, rose even more rapidly, putting a strain on all forms of health insurance. **Figure 26-1** shows the growth in medical care expenditures in the United States since 1960. In that year, approximately \$27 billion was spent on medical care. In 1970, the figure had grown to \$74 billion. By 2007, national health expenditures were over \$2.2 trillion dollars

per year.¹ The rate of increase averaged about 2.5 percent above the overall growth rate of the economy.² Because of their faster growth rate, medical costs have constituted a larger and larger percentage of the nation's gross domestic product (GDP). In 1960, medical expenditures were about 5 percent of the GDP; in 2007, they were 16.2 percent.¹

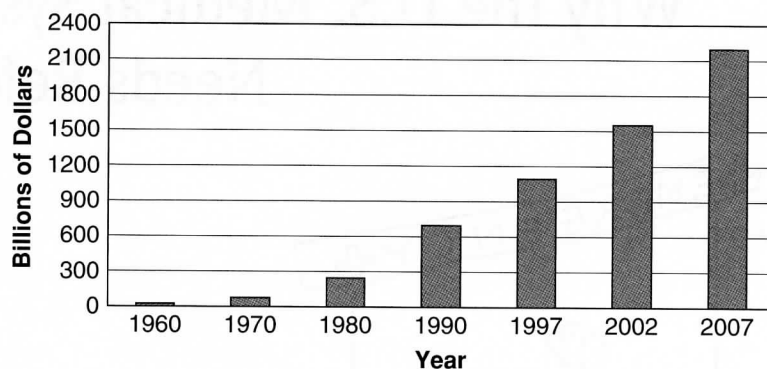


FIGURE 26-1 U.S. Healthcare Expenditures Between 1960 and 2007.

Source: Data from *Health Affairs* 13 (5), 14–31 (1994); and 28 (1), 246–261 (2009).

Although expenditures on health have risen all over the world, the United States spends far more on medical care per person than any other country in the world. In 2005, an average of \$6401 was spent on health costs for each American, more than twice the average of a group of thirty industrialized countries that are members of the Organization for Economic Cooperation and Development (OECD) (see Figure 26-2). Spending as a percentage of GDP is also highest in the United States, amounting to 15.3 percent in 2005; Switzerland follows at 11.6 percent; and the average for the thirty OECD countries was 9.1 percent.²

There is no evidence that Americans are healthier as a result of the greater expenditures. As measured by the common indicators of health status used for international comparisons, the United States does poorly. Of 37 countries compared in 2005, the United States ranked 30th in infant mortality; its life expectancy at birth was 23rd for males and 25th for females in 2004. We did better in life expectancy at age 65, ranking 9th for both males and females.³

Problems with Access

Despite the large expenditures, many Americans have difficulty getting access to medical care when they need it. About 46.3 million people, or 15.4 percent of the population, lacked health insurance for the entire year in 2008.⁴ Many more may be uninsured for part of the year. The

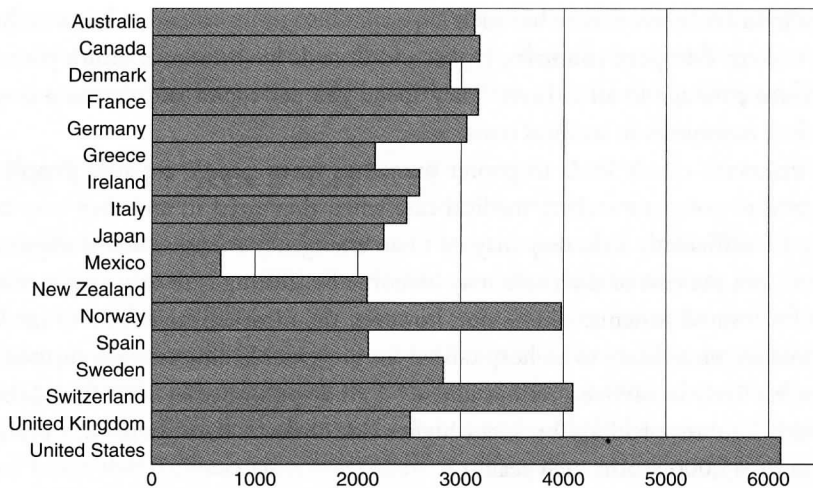


FIGURE 26-2 Per Capita Health Spending in Selected OECD Countries.

Source: Data from *Health Affairs* 26 (5), 1481–1489 (2007).

numbers have been increasing and are predicted to continue to rise unless the government reforms the system. Most of the uninsured are poor but not poor enough to qualify for Medicaid. The percentage of children who are uninsured has declined to less than 10 percent because of the Children's Health Insurance Program passed in the 1990s. But young adults are the group most likely to be uninsured: 28.6 percent of those ages 19 to 24 and 26.5 percent of those ages 25 to 34. Members of racial and ethnic minority groups are more likely to be uninsured than white Americans: about 19 percent of African Americans and almost 31 percent of Hispanics were uninsured in 2008, compared with 10.8 percent of whites.⁴ Many of the uninsured are patients with chronic diseases who are closed out of the market because of policies that deny coverage for preexisting conditions or that charge exorbitant premiums for people whose health is poor.

The problem of access to medical care is closely related to the problem of its cost. As monthly premiums have risen in proportion to wages, it has become increasingly expensive for employers, especially small businesses, to provide health insurance for employees and their families. Employers have cut back on their coverage, shifting more of the costs to the employees by requiring them to pay a larger share of the premiums, higher deductibles, and higher copayments. Some low-wage workers may choose to remain uninsured because their share of the premiums is too high; yet these workers earn too much to qualify for Medicaid in most states. Nearly 83 percent of the uninsured live in families headed by workers. Uninsured workers are mostly employed in blue-collar jobs or service-sector jobs.⁵

No other industrialized country has such large numbers of uninsured citizens as the United States. The western European countries, Japan, and Canada have national health plans that virtually guarantee coverage to all citizens. They spend less per capita and devote a smaller percentage of their economies to medical costs.

Lack of insurance clearly leads to poorer outcomes when people are sick. People who are uninsured tend to postpone seeking medical care when they need it, and they may be denied care. If they are sufficiently sick, they may go to an emergency room, which is required by law to treat them, and the cost of their care may be borne by shifting it to other payers, increasing the charges for insured patients. This is not, however, the most effective form of medical care. The uninsured are more likely to be hospitalized for preventable illnesses than insured patients, and they are less likely to survive a serious illness.⁶ A study published in 2009 found that people without health insurance had a 40 percent higher risk of death than those with private insurance, leading to 45,000 deaths each year.⁷

Although Medicare has ensured that most of the elderly have access to medical care when they need it, escalating costs have had an impact here, too. Each year the program pays out more than it collects in premiums, and Congress has repeatedly tried to make adjustments to save the system from bankruptcy. In 2008, 13 percent of the federal budget went to Medicare, and spending is growing at an unsustainable rate.⁸ Attempts to cut costs are politically delicate because the elderly are fiercely protective of their entitlements. Because of the overall growth of medical expenses generally, together with requirements for beneficiaries to pay deductibles and copayments, the elderly now pay on average over 16 percent of their income out-of-pocket for medical care. Most have some form of supplemental insurance plan.⁸

Medicaid has never worked as well as it was expected to. Although federal law requires coverage for all children under six and pregnant women whose family income is below 133 percent of the federal poverty level, eligibility for the children's parents is set by the states and varies considerably. In some states, the fixed fees that the program pays to providers are so low that doctors are unwilling to participate in the program, making it difficult for families that have coverage to find someone to treat them other than poor-quality "Medicaid mills." Even so, the growing costs of Medicaid are placing a strain on many state budgets, using funds that might otherwise be used for education or other services. Although the majority of Medicaid beneficiaries are children, their parents, and pregnant women, most of the spending goes to long-term care for the elderly and disabled, as discussed in Chapter 28.⁹

Overall, although the American medical system is the most expensive in the world, it is highly inefficient. The United States spends a higher proportion of its resources on health care than other countries; at the same time a significant proportion of the population is denied services, a

situation almost unheard of in other countries. Moreover, the health status of the American population is poor in international comparisons—evidence that all the spending on medical care cannot compensate for failures in the public health system, as discussed in Chapter 27.

Why Do Costs Keep Rising?

A number of factors are responsible for the high and rising cost of medical care in the United States, some of them common to all industrialized countries, some unique to the American system. The aging of the population, for example, is a problem common to most countries. Because older people generally have a greater need for medical care, aging populations are driving up medical expenditures everywhere. In fact, several other countries have older populations than the United States. The problem of medical costs and aging is discussed in Chapter 28.

Another factor that increases costs everywhere is the continual development of new medical technology and high-tech procedures. New instruments such as computed tomography (CT) scanners and magnetic resonance imaging (MRI) devices and new procedures such as arthroscopic and laparoscopic surgery and cardiac catheterization are expensive. They can be very effective in diagnosing and treating illness, so they are used widely—perhaps too widely. However, these technologies are available in all advanced countries, and it is not clear that they are more widely used in the United States.¹⁰

When inflationary factors that are unique to the American system are considered, administrative costs are one of the favorite targets of blame. According to one recent estimate, 31 percent of the American medical budget is spent on administration. Twenty-seven percent of medical workers in the United States spend most of their time on paperwork, up from 18 percent in 1968.¹¹ Because many different insurers pay for medical care, each with its own forms and documentation requirements, the process of billing and paying for care in the United States is much more time consuming and expensive than in countries where the government pays for everything. Moreover, some insurance companies, in trying to control costs, institute additional administrative procedures, for example requiring doctors to justify the need for certain treatments. This has the paradoxical effect of increasing paperwork and the percentage of effort and expense that goes to administration. As one eminent health economist lamented: “I look at the U.S. healthcare system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason.”¹²

Another peculiarly American characteristic that adds to medical costs is our tendency to sue for malpractice when something goes wrong. Doctors complain about the exorbitant price of malpractice insurance, and occasional news stories tell of a multimillion-dollar jury award to an unfortunate patient who was harmed by some medical procedure. Although these costs do not

in themselves have a significant overall impact, the fear of malpractice suits may affect a physician's decisions. Doctors may practice "defensive medicine," ordering more diagnostic tests and medical procedures than necessary, to document in court that they did "everything possible" for the patient.

In fact, studies have shown that the whole system of malpractice compensation is inefficient and unjust. Most patients who are harmed by poor medical treatment are not compensated, and many patients who have suffered a bad outcome sue and win, even when the medical provider was not negligent.¹³ However, because the United States does not have a national health plan, winning a malpractice suit may be the only way an injured patient will be able to pay for treatment of his injury.

One analysis of why medical spending in this country is higher than in other OECD countries found that the United States has higher rates of chronic diseases associated with obesity, including diabetes and heart disease. As discussed in Chapter 16, almost two thirds of Americans are overweight or obese, far outnumbering the prevalence in other countries, where, on average, 47 percent of the population has a BMI greater than 25.¹⁰

Among the most significant factors driving up medical costs are financial incentives for medical providers. In the "fee-for-service" system of payment, doctors and hospitals are motivated to provide more services in order to increase their income. Moreover, the performance of surgical procedures and the use of high-tech diagnostic equipment are more profitable than the more time-consuming practices of talking, listening, observing, and touching. Along with the growth of new medical technologies has come the growth of specialization among physicians. Fewer than 50 percent of doctors in the United States work in primary care, which includes family practice, general internal medicine, pediatrics, and obstetrics/gynecology. The majority of American physicians practice the more lucrative technological specialties such as radiology, anesthesiology, ophthalmology, cardiology, gastroenterology, and urology. Because of the relatively low pay for primary care providers, many patients looking for an internist or pediatrician may not be able to find one.¹⁴

Conspiring with providers in forcing up costs are the expectations of the medical care "consumer"—the patient. Patients with traditional insurance do not have to consider the costs of their care in making decisions on how they should be treated, because the bills will be paid by their insurance company. Thus they demand "the best" in technology, treatment by specialists, and prompt service. Economists point out that the medical marketplace is different from classical markets, which are sensitive to the price of goods and services. In the medical marketplace, the seller (the doctor) rather than the buyer (the patient) determines what the buyer needs. Sellers also set the price, and because the bill is paid by a third party (the insurance company), there is no incentive for the buyer to select less expensive options.

Approaches to Controlling Medical Costs

Of the total amount spent on medical care in the United States, 46.2 percent is paid by federal, state, and local governments. About 35 percent is paid by private health insurance sponsored by employers.¹ Thus, both governments and employers have reason to try to control costs, and they have tried a variety of approaches to achieve that goal. The first cost control effort by the federal government was the imposition of price controls by President Nixon from 1971 to 1974. Although the policy moderated cost increases temporarily, providers adapted to the lower fees paid for each service by increasing the quantity of services. Total spending continued to rise.

Another regulatory approach to cost control focused on limiting spending on new facilities and technology. This is a major strategy used by other OECD countries to control their costs. In the 1970s the federal and some state governments tried to constrain the supply of hospital beds and high-tech equipment by establishing regional planning agencies that would assess the need for capital expenditures and issue certificates-of-need for new investments. Without limits on budgets, however, there were few incentives for state or local governments to control these expenditures. Considerable political pressure also served to force approval of new projects. In the 1980s, certificate-of-need programs were gradually abandoned as ineffective.

In the 1980s, the Medicare program tried a different approach to cost control. Because the greatest expenditures were payments to hospitals, the program devised a payment system designed to provide incentives for hospitals to limit the length of hospital stays. Medicare paid a flat fee for each hospital stay, an amount based on the illness category of the patient, or diagnosis related group (DRG), and the average cost of treating similar patients throughout the country. If a hospital could cure the patient in a shorter time than average, it could keep the extra cash. If a longer stay was necessary, the hospital had to swallow the additional cost. Hospitals, in response, began charging private insurance companies more to make up for their losses from the government; so several states adopted DRG-type rate-setting systems for all payers, forcing hospitals to accept the same rates for everyone. One result of policies limiting payments to hospitals was to move more treatment out of the hospital. Hospital stays are on average much shorter now than they were two decades ago, and outpatient surgery and diagnostic testing have become the rule. The DRG system was effective in reducing expenditures for hospital care, but overall costs continued to rise because there was no DRG system for outpatient care.

Managed Care and Beyond

Employer-based private insurance plans have tried a number of approaches to limiting costs by bargaining with providers—doctors and hospitals—for discounts on services. The result is a variety of plans that fall under the category of managed care. For example, in preferred provider organizations (PPOs), patients are required to seek care from participating providers who have agreed to provide services at lower rates. In some of these plans, patients are not allowed to see a specialist without a referral from a primary care physician, a strategy for limiting access to expensive high-tech care as well as for ensuring coordination of the care received by the patient from various providers. A variation on the PPO arrangement allows patients to go to nonparticipating providers but requires them to pay a higher percentage of those costs out of their own pockets.

The most stringent form of managed care is the health maintenance organization (HMO), so called because—in theory at least—the organization has a financial incentive to maintain the health of its members. An HMO acts as both insurer and provider. In return for a fixed monthly or annual payment, the HMO agrees to provide all the medical care the individual needs. Conventional HMOs hire a staff of physicians, nurses, and other healthcare workers who earn a salary and thus have no incentive to provide expensive treatments when not necessary. Moreover, HMOs have incentives to provide preventive care and health promotion programs, adopting some of the goals and objectives of public health.

Managed care flourished in the 1990s. With the continued rise of medical costs and the failure to enact President Clinton's plan for healthcare reform, employers moved to restrict the choices of their employees to plans that incorporated cost control measures. In 1995, almost three-quarters of workers covered by employer-sponsored insurance were in managed care plans.¹⁵ States began to move Medicaid recipients into managed care plans in the hope of providing them with a higher quality of care and more continuity of care, as well as controlling Medicaid costs. The Medicare program also tried to encourage more of the elderly to enroll in managed care plans. The result was a dramatic slowing of medical inflation in the 1990s.¹ However, the slowdown did not last.

With the success of managed care came some major criticism and what was called "the HMO backlash."¹⁶ Patients understood that the financial incentives encouraged denial of treatment, and they were outraged, even when some of the treatments denied were of unproven efficacy. Some for-profit HMOs had especially objectionable practices of giving bonuses to physicians who were most successful in denying care. Patients also objected to limits on their choice of doctors to consult. News stories told of HMO "gag rules" that forbade physicians from recommending treatments for which the HMO would not approve payment. Many state legislatures passed laws prohibiting gag rules. Similarly, states passed laws regarding "drive-

through deliveries” and “drive-through mastectomies” in response to managed care plans that limited hospital stays for women giving birth or having cancer surgery. In 1996 alone, 56 laws were passed in 35 states aimed at regulating or weakening HMOs.¹⁶ The result of such laws, together with some important decisions in federal courts that favored consumers’ right to sue HMOs for denial of care, meant that managed care organizations lost much of their ability to manage medical care in a cost-conscious way.¹⁷

Despite the complaints about managed care, including well-publicized instances of patients’ being denied expensive procedures that might have saved their lives, there is no evidence that patients are harmed by the cost-control measures overall. In many ways, managed care has an advantage over fee-for-service in providing high-quality care. The emphasis on prevention and health education may indeed help to keep members healthy. Coordination of care and use of interdisciplinary teams for disease management can help to prevent patients with chronic diseases from developing severe and costly complications. The use of primary care physicians as gatekeepers for controlling patient access to specialists may help to prevent unnecessary procedures that could put patients at risk. Managed care organizations, because of centralized record-keeping, have the ability to monitor patients’ health and to evaluate the quality of care they receive, as discussed in Chapter 27.

The result of the weakening of cost control methods used by managed care organizations was that medical spending began to grow again in the late 1990s and early 2000s, although at a slower rate. Plans became less restrictive, and PPOs became more popular because they allow more choices. Health insurance became less affordable. More of the costs are shifted to the patients. The problems of the uninsured have grown worse. When fee-for-service was the norm, hospitals could charge higher rates to insured patients to cover the costs of treating the uninsured, as they are often required to do by law (see Chapter 25). Now, however, managed care organizations, even the weaker ones, negotiate reduced payments for treatment of their members, and hospitals are less able to cost-shift, causing financial pain for the hospitals. While some states provide special payments to hospitals to cover bad debt and charity care, antitax sentiment discourages such public funding for the poor. Private hospitals select the most profitable patients, and stories of patient “dumping” have become common. Public hospitals in inner cities bear the brunt of caring for the sickest uninsured patients, and many must cut back on services or threaten to close because of lack of funding.¹⁸

An approach to controlling medical costs, called consumer-directed health plans, is popular among political conservatives and was encouraged during the Bush administration. The intent of these plans is to make consumers more cost-conscious when they seek medical care by providing them with information on cost and quality and requiring them to share more of the cost. The plans tend to have high deductibles, so that insurance payments do not kick in until after individuals themselves have paid for a significant amount of services, and they tend to be

combined with health savings accounts, in which individuals set aside funds tax-free to be used in paying for medical expenses. A number of drawbacks have been noted with these plans, including that they are most likely to be used as a tax haven for healthy and wealthy individuals. Another difficulty is that they motivate people to avoid, skip, or delay health care because of costs, sometimes leading to more serious disease and increased risk of needing hospitalization.¹⁹

Now that President Obama has declared his intent to try again to reform the medical care system, a number of ideas have been proposed to improve its efficiency and effectiveness. Some of the key ingredients are electronic medical records, which would greatly reduce paperwork, improve coordination of care, and reduce medical errors; comparative effectiveness research, which would help inform doctors about what treatments are best for which patients (discussed in Chapter 27); and adjustment of payment formulas to encourage more primary care doctors who are more likely to provide economical and coordinated care. What seems clear to many is that something must be done to bring costs under control. As one analyst notes, the U.S. healthcare system is on the verge of a “tragedy of the commons” (see Chapter 2). The major participants in the system—providers, payers, and patients – are merely doing what is rational given the current incentives and rules of the game. However, unless the rules and incentives are changed, “the U.S. healthcare system will continue its trajectory of unsustainability to the point of collapse.”²⁰

Rationing

In the late 1980s, the state of Oregon tried an experiment. Realizing that its Medicaid budget was not large enough to provide comprehensive coverage for all of its poor citizens, the state legislature undertook a plan to spread its resources over a larger number of people by limiting the services for which it would pay. Its first move was highly controversial. It decided not to pay for organ transplants, with the justification that the funds required for 34 transplants could provide for prenatal care and delivery for 1500 pregnant women.²¹ When a young boy with acute leukemia was denied a bone-marrow transplant and died as a result, there was a national uproar.

The legislature, led by John Kitzhaber, a physician who was then president of the state senate and later became governor, decided to develop a more acceptable policy for broadening Medicaid eligibility. The new approach focused on life-saving treatments for serious conditions and tried to eliminate less effective therapies for less serious conditions. The state decided to develop a prioritized list of health services and draw a line below which treatments would not be covered. The goal was to cover all citizens whose incomes were below the poverty level, and to use managed care plans to provide medical care.

A commission was formed to develop the list by consulting as much as possible with the citizens of the state. Public hearings and town meetings were held to determine the relative value placed on various medical services by the public. The commission established seventeen categories of health problems according to thirteen criteria, including life expectancy, quality of life, the cost-effectiveness of a treatment, and the probable number of people who would benefit. The highest priority was placed on acute problems that could be fatal and for which treatment would provide full recovery. Surgery for appendicitis is an example of a high-priority procedure. Other highly ranked services included maternity care and preventive care for children. At the bottom of the list were treatments known to be ineffective, or those that did not improve quality of life or extend life, including some treatments for cancer and AIDS.²²

The Oregon plan provoked opposition on legal, social, and ethical grounds. In 1991 the Department of Health and Human Services denied permission for Oregon to implement the plan on the basis that it violated the Americans with Disabilities Act, because the list undervalued the quality of life of people with disabilities. After some revisions, the plan was finally approved by the Clinton administration in 1993. More than 100,000 Oregonians were added to the Medicaid program as a result.²²

Many critics have pointed out that the policy would be more equitable and that the decisions would be much less difficult if everyone—not just the poor—were included in the rationing proposal. The medical system as a whole is rich enough to provide necessary care for everyone; the need to ration care for the poor is a consequence of failures of the system to provide adequate and affordable care for everyone. Health policy experts have praised the Oregon plan's focus on medical necessity so that all appropriate care and no inappropriate care is covered. It called attention to the need for more research on outcomes of various treatments to permit better informed decisions on medical necessity (see Chapter 27). Some of these lessons may be useful in devising a new national plan if President Obama succeeds in getting one passed.

However, the Oregon Plan, while still officially in effect, is now struggling badly. In part, its difficulties stemmed from an attempt in 2002 to expand it further to include additional uninsured residents, which happened at a time when the state was undergoing an economic downturn. Oregonians, like other Americans, resisted increasing taxes to finance the program. In part, the program faltered because Governor Kitzhaber was term limited, and his successor was not such an enthusiastic defender of the plan. Also, in Oregon, as in the rest of the country, medical care costs began growing faster than the general economy, making the provision of health care for all economically and politically more and more difficult.²³

The Oregon experiment makes many people uncomfortable. People do not like to confront the idea that rationing medical care might be necessary or desirable. In fact, however, rationing medical care has been going on all along: care has been rationed on the basis of ability to pay,

but the rationing has not been explicitly admitted. When a story hits the news about an uninsured child denied treatment for leukemia, for example, the public and politicians purport to be shocked that such a thing could happen in our society. Yet it is politically impossible to raise taxes so that such children could be provided with medical insurance or that public hospitals could afford to provide effective care.

Our society has never been willing to discuss tradeoffs between costs and quality of medical care.²⁴ Because third parties—usually the government or insurance companies—pay for care, people have come to believe that cost should not be considered when decisions are made about medical treatments. When asked about a particular patient or situation, people will say that no effort should be spared in trying to achieve the best possible outcome. It is an easy thing to say when they are not paying the bills. At the same time, people naturally seek out insurance plans with the lowest premiums. It is a catch-22 situation: society demands that the healthcare system maximize quality while minimizing costs, but it has placed a taboo on the consideration of cost.²⁴

Rationing is a dirty word when it applies to medical care. But rationing is inevitable. In economics, “rationing is simply the process of allocating goods in the face of scarcity.”²⁵ Since most people are unwilling to pay an unlimited amount of money to receive a small benefit, decisions are continually being made on allocation of medical services. What is needed is an open discussion on how those decisions should be made. Should kidney dialysis be denied to the elderly or to people with diabetes so advanced that they have lost their vision? Should we tolerate long waiting lists for hip replacements? Should the rich receive care and the poor be denied it? Should we allow for-profit healthcare systems that make large profits for their stockholders while refusing to care for patients with expensive chronic diseases?²⁶ These are difficult questions for medicine and for public health, but we need to openly discuss them and decide on a societal basis.

Conclusion

The U.S. medical care system is the most expensive in the world. At the same time, it has many faults, including lack of access for the uninsured, about 16 percent of the American population. Medical care costs have risen continuously, and the rising costs contribute to the inability of many to afford health insurance.

There are a number of reasons for the high and rising costs. An aging population needs more medical care; expensive new medical technologies are regularly developed and widely used; administrative costs are high in the United States; malpractice suits lead to defensive medicine; insured patients are shielded from consideration of costs; and financial incentives often favor overtreatment.

A number of attempts to impose cost-containment measures on medical care have been relatively unsuccessful in controlling costs. Managed care slowed the growth in healthcare costs in the 1990s and has consequently become the dominant form of employer-sponsored health insurance. Managed care organizations negotiate reduced payments to healthcare providers and employ various strategies to limit patients' access to treatments considered nonessential or too expensive for the expected benefit. Despite its successes, managed care has been unpopular with the public, and it has not improved access for the uninsured. Because of its unpopularity, managed care has suffered legislative and legal setbacks that have weakened its ability to control costs. Medical care expenditures have resumed their escalation, and it is not clear how the nation can pay for medical care in the future.

Many health policy makers believe that some form of rationing will ultimately be necessary to ensure access to high-quality medical care for the whole population. They point out that care is already rationed by cost. In Oregon, the Medicaid program, using an explicit method of ranking various treatments and cutting off access to lower priority procedures, significantly expanded the number of people covered by the plan; but the plan has faltered due to rising costs and state economic setbacks. Discussion of rationing is largely taboo in the current political climate, but if the problems of the system continue to grow, Americans may be forced to consider cost and fairness when making decisions about medical care.

President Obama has set a priority on reforming the American healthcare system, and Congress has been attempting to pass a plan that would control costs and provide health insurance to more of the population. As this book is being finalized, in early 2010, the prospect of achieving that goal is still unclear.

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